MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04261 04263

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Martin Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport 21-1
d. STREET ADDRESS: Canal Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Elizabeth — Last: Ardinger

4. DATE OF DEATH: Month: March — Day: 24 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 29 1889

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months: 1 — Days: 22 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Charles Ardinger

14. MOTHER'S MAIDEN NAME: Lula Woltz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ------

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Ida Ardinger — Address: Canal Rd. Williamsport Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Advanced arteriosclerosis, generalized, — 5-10 yrs

DUE TO (c): + Cerebral thrombosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Mar 1 - 19 67, to Mar 24, 1967, that (I) (we) last saw the deceased alive on Mar 11 1967, and that death occurred at 2 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edward W Dillon III — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-24-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: 217 W. Washington St Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 27-67

23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

23d. LOCATION (City, town or county) (State): Williamsport Maryland

24. FUNERAL DIRECTOR ADDRESS: Albert L.. Leaf Williamsport Maryland

25a. REC'D BY REGISTRAR: MAR 28 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04262

CERTIFICATE OF DEATH

04264

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 5 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Washington County

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Pennsylvania
   b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro 75-3
   d. STREET ADDRESS: 26 W. 3rd St.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ethel; Middle: May; Last: Balsiger

4. **DATE OF DEATH**: Month: 3- Day: 10- Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-17-02

9. AGE (In years last birthday): 64 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - -

11. BIRTHPLACE (County & State, or foreign country): Franklin Co. Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard King

14. MOTHER'S MAIDEN NAME: Minnie Schrader

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: - -

17. **INFORMANT**: Mr. H. E. Balsiger — Address: Waynesboro, Penna.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Gastrointestinal and intracranial hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO
   (b): Acute thrombocytopenic purpura.
   DUE TO
   (c):
   296X
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-5-67, 19___, to 3-10-67, 19___, that (I) (we) last saw the deceased alive on 3-9-67 19___, and that death occurred at 3:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: A. F. Abdullah M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-13-67

22c. PHYSICIAN'S NAME (Type): A. F. Abdullah, M. D.

22d. ADDRESS: 132 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/12/1967

23c. NAME OF CEMETERY OR CREMATORY: Green Hill

23d. LOCATION (City or Town) (County) (State): Waynesboro, Franklin, Pa.

24. FUNERAL DIRECTOR: Walter G. Gore — ADDRESS: Waynesboro, Penna.

25a. REC'D BY REGISTRAR: DATE MAR 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04263 04265

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Williamsport RFD #2 21-1
d. STREET ADDRESS: Pinesburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ezra — Middle: Keller — Last: Banzhoff

4. DATE OF DEATH: Month: March — Day: 26 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 14 1874
9. AGE (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months: 1 Days: 11 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fishing Guide
10b. KIND OF BUSINESS OR INDUSTRY: Fishing
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: William Banzhoff
14. MOTHER'S MAIDEN NAME: Mary Unger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — ------
16. SOCIAL SECURITY NO.: 216 03 1226A
17. INFORMANT: Mr. Amos Banzhoff — Address: Williamsport Md RFD #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Brain Hemorrhage and contusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
9000
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): accidental fall down basement steps
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Accidental fall down basement steps
20c. TIME OF INJURY Hour a.m. 2:00 p.m. — Month, Day, Year: 3/26/67 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Wmspt. — (County): Wash. — (State): Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/27/67

EXAMINER'S NAME (Type): Howard N. Weeks, M. D.
Address (Street, city, town, or county): 580 Northern Ave., Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 29-67
22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport, Md.

23. FUNERAL DIRECTOR — ADDRESS: Albert L.. Leaf Williamsport Md..
24a. REC'D BY REGISTRAR — DATE: MAR 28 1967
24b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04264 04266

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leitersburg
c. LENGTH OF STAY IN 1b: 17 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rd # 5

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leitersburg 21-1
d. STREET ADDRESS: Rd # 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Elmer Middle: William Last: Bingaman
4. DATE OF DEATH: Month: March Day: 11 Year: 19 67
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-25-06
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: Steel mfg.
11. BIRTHPLACE (State or foreign country): Welsh Run, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John E. Bingaman
14. MOTHER'S MAIDEN NAME: Martha Mummert
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): no
16. SOCIAL SECURITY NO.: 174-01-3577
17. INFORMANT: Ella Bingaman Address: Leitersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation due to — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Carbon Monoxide — 15-30 Min
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9731
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot I took charge of the remoins described above, held on Autopsy ☐, Inspection ☑ Inquiry ☑ and in my opinion deoth resulted from: Noturol causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Edward W DiHo III, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
EXAMINER'S NAME (Type): Edward W. DiHo III, M.D. Address (Street, city, town, or county): 217 W. Washington St Hagerstown, Md
22. DATE SIGNED: 3-13-67

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3-14-67
23c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Waynesboro, Pa.
24. FUNERAL DIRECTOR: Minnich Funeral Home ADDRESS: Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE: MAR 15 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04265

CERTIFICATE OF DEATH

04267

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cascade 21-1
d. STREET ADDRESS: Rd 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Edith — Middle: Blanche — Last: Boppe

4. **DATE OF DEATH**: Month: March — Day: 15 — Year: 19 67

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-6-1892

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (County & State, or foreign country): Indian Springs, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Grove

14. MOTHER'S MAIDEN NAME: Anna Penner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Wm. A. Boppe Cascade, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive repeated hemorrhage into gastro-intestional tract. — INTERVAL BETWEEN ONSET AND DEATH: intermittently 16 hours.
578X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Unknown
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Atherosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 14, 1967, to March 15, 1967, that (I) (we) last saw the deceased alive on March 15 1967, and that death occurred at 2:05 A.M., from causes and on the date stated above.

22a. SIGNATURE: William T. Layman, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: March 17, 1967

22c. PHYSICIAN'S NAME (Type): William T. Layman, M.D.

22d. ADDRESS: 100 Professional Arts Bldg. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-18-67

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR — ADDRESS: Minnich Funeral Home Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18-21 Film 387 4-5-67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Form PM5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04266 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04268

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Cascade
   c. LENGTH OF STAY IN 1b: 1 Week
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Cascade — 21-1
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Shirley — Middle: Viola — Last: Bowman

4. **DATE OF DEATH**: Month: March — Day: 6 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/25/35

9. AGE (In years last birthday): 32 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Smithsburg Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Marshall Bowman

14. MOTHER'S MAIDEN NAME: Mary F. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: Box 5
Mrs. Marshall Bowman, Route #1, Cascade Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Exposure — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO (b): Pneumonia, Hypostatic, Bronchial, Right
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 932.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Wandered away from home into Mountain area - apparently succumbed to elements

20c. TIME OF INJURY Month, Day, Year: Unknown — Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Mountain Area

20f. (City or town) nr. Ft. Ritchie (County) Wash. (State) Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Edward W. Ditto III, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Edward W. Ditto III, MD
Address (Street, City, Town or County): 21 West Main St Waynesboro Pa.

22. DATE SIGNED: 3-11-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/13/67

23c. NAME OF CEMETERY OR CREMATORY: Bethel

23d. LOCATION (City or Town) Lantz #1 (County) Frederick Co., Md. (State)

24. FUNERAL DIRECTOR: Walter Y. Grove,
ADDRESS: Waynesboro Pa.

25a. REC'D BY REGISTRAR DATE: MAR 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04267 — 04269

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 50 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Martin Manor Rest Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: 16 Avalon Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jessa — Middle: Pearl — Last: Brill

4. **DATE OF DEATH**: Month: March — Day: 4 — Year: 19 67

5. SEX: Feamle

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 21, 1887

9. AGE (In years last birthday): 80 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Lincoln, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alexander P. Fletcher

14. MOTHER'S MAIDEN NAME: Jessa Grady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-30-9543

17. INFORMANT: A.F. Brill — Address: 29 Redwood Dr. Hagerstown, Md.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Adeno Carcinoma Colon & Sexual — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO
   (b): izel Metastasis — 1 yr
   DUE TO
   (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   1538

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 12-21-, 1966, to 3-4-, 1967, that (I) (~~we~~) last saw the deceased alive on Feb 25 1967, and that death occurred at 3:35 M, from causes and on the date stated above.

22a. SIGNATURE: Edward W. Ditto III, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-4-67

22c. PHYSICIAN'S NAME (Type): Edward W. Ditto III, MD

22d. ADDRESS: 217 W. Washington St. Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/6/67

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown, Washington, Md.

24. FUNERAL DIRECTOR: Wm. E. Hoot — ADDRESS: Rest Haven Funeral Chapel, Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: MAR 7 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 haurs after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04268

CERTIFICATE OF DEATH

04270

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
c. LENGTH OF STAY IN 1b: 6 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Avalon Manor, Inc.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Rural Smithburg 21-1
d. STREET ADDRESS: Holiday Acres, Box 262
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edith — Middle: Catherine — Last: Brown

4. DATE OF DEATH: Month: March — Day: 17, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: March 16, 1893

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: 0 — Days: 1
IF UNDER 24 HRS.: Haurs — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Lansing, Michigan

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Charles Foerster

14. MOTHER'S MAIDEN NAME: Mary Sandowsky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown) (If yes give war ar dates of service): No.

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. James M. Archer — Address: 2131 Fairfax Rf. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(b): Arteriosclerotic Cerebral Vasc. Disease — 2 yrs
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City ar town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct, 1966, to March 17, 1967, that (I) (we) last saw the deceased alive on Mar 17 1967, and that death accurred at 4:30 A.M., from causes and an the date stated above.

22a. SIGNATURE: Lloyd A. Hoffman M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 3/18/67

22c. PHYSICIAN'S NAME (Type): Lloyd A. Hoffman

22d. ADDRESS: 214 N. Pat. St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 2- 19- 67

23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery

23d. LOCATION (City or Town) (County) (State): Lansing Michigan

24. FUNERAL DIRECTOR — ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.

25a. REC'D BY REGISTRAR DATE: MAR 21 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04269 04271

1. PLACE OF DEATH
a. COUNTY: WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN
c. LENGTH OF STAY IN 1b: 5 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): AVALON MANOR NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: PENNSYLVANIA b. COUNTY: FRANKLIN ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL FAYETTEVILLE 75-3
d. STREET ADDRESS: R.D.# 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUELLA Middle RINEHART Last CASPER
4. DATE OF DEATH: Month MARCH Day 12 Year 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 14, 1895
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PARTNER
10b. KIND OF BUSINESS OR INDUSTRY: ORCHARD
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON CO., MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: EDMUND P. COHILL
14. MOTHER'S MAIDEN NAME: MARY RINEHART
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 212-38-9683A
17. INFORMANT: MR. JOHN P. CASPER R.D.#3 Address: FAYETTEVILLE PENNSYLVANIA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myeloid metaplasia of Spleen — INTERVAL BETWEEN ONSET AND DEATH: 6 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
2981

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-9, 1962, to 3-12, 1967, that (I) (we) last saw the deceased alive on 3/11 1967, and that death occurred at 3:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: John H Hornbaker M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-13-67
22c. PHYSICIAN'S NAME (Type): JOHN H. HORNBAKER M.D.
22d. ADDRESS: 154 W. WASH. ST. HAGERSTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MARCH 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: HOMEWOOD CEMETERY
23d. LOCATION (City or Town) (County) (State): PITTSBURGH, PENNSYLVANIA

24. FUNERAL DIRECTOR: CHARLES M. ROUZER ADDRESS: HAGERSTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAR 17 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0&270

CERTIFICATE OF DEATH

04272

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Knoxville c. LENGTH OF STAY IN 1b: 3 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Knoxville Rfd. 1 21-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress)	d. STREET ADDRESS: Weaverton e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
Elsie	O.	Castle	March	31,	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		June 5, 1906	60 yrs.	9	26		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Middletown, Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ira C. Moss	Hattie Mae Cochran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address: Knoxville, Md.
No.	215-26-8159	Mr. Cornelius W. Castle, Jr. Rfd. 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

DUE TO (b): Arteriosclerotic Heart Disease — Years

DUE TO (c):

Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse lost.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 5-7-, 1963, to 1-9-, 1967, that (I) (we) last saw the deceased alive an 1-9- 1967, and that death accurred at 4P M, from causes and an the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Joseph Secondari		4.1.67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
JOSEPH SECONDARI	BOONSBORO Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-3-67	Brownsville Cemetery	Brownsville, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.	APR 4 1967	[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04271

04273

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAHERSTOWN
c. LENGTH OF STAY IN 1b 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN MARYLAND
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle Last CHANEY

4. DATE OF DEATH Month 3 Day 25 Year 19 67

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 10.30.1904

9. AGE (In years last birthday) 62 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country) CLEARSPRING MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILLIAM CHANEY

14. MOTHER'S MAIDEN NAME SUSAN M POWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 213.24.9699

17. INFORMANT MARTIN VB.BOSTER Address 34 W.FRANKLIN ST. HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b) arteriosclerotic heart disease — years
DUE TO
(c) generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 23 March 1967, to death, 19___, that (I) (we) last saw the deceased alive on 25 March 1967, and that death occurred at ___ M, from causes and on the date stated above.

22a. SIGNATURE John C. Stauffer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 27 March 67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE THEREOF 3.29.67

23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEMORIAL

23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD.

24. FUNERAL DIRECTOR Howard F Stone ADDRESS Hancock md

25a. REC'D BY REGISTRAR DATE MAR 31 1967

25b. REGISTRAR'S SIGNATURE J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04272 04274

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 70 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): 733 MARYLAND AVENUE

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn): HAGERSTOWN 21-1
d. STREET ADDRESS: 733 MARYLAND AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
HARRY	THOMAS	CLARK	MARCH	24	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Haurs / Min.
MALE	WHITE		JULY 12 1874	92 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State & State, ar foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED MERCHANT	LIQUOR STORE	PHILADELPHIA PENNSYLVANIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS CLARK	CECILIA STOLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknawn) (If yes give war ar dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
NO	214-09-9106A	MRS MYRA L MARTIN	957 VIEW STREET HAGERSTOWN MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coromry occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying couse last. 4201
(b): Arteriosclerotic heart disease — Indefinite
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture af injury in Part I ar Part II of item 18.)
20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Nat While at work ☐
20e. PLACE OF INJURY (Hame, farm, factary, street, office bldg., etc.)
20f. (City ar tawn) (Caunty) (State)

21. **I certify** that (I) ~~(XXXXXXX)~~ attended the deceased from Dec. 13, 19 63, ta March 24, 19 67, that (I) ~~(XX)~~ last saw the deceased alive on March 23 19 67, and that death accurred at 12:15A. M, from causes and an the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
B.B. Kneisley		3/25/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
B.B. KNEISLEY M.D.	148 W WASHINGTON ST. HAGERSTOWN MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (Caunty) (State)
BURIAL	3/27/67	ROSE HILL CEMETERY	HAGERSTOWN WASHINGTON MD

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
CHARLES M ROUZER HAGERSTOWN MARYLAND	MAR 28 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05273 — Reg. Dist. No. 04275

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Jackson Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 45 N. Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Athalinda; Middle:; Last: Creager

4. DATE OF DEATH: Month: March; Day: 10; Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 12, 1879

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Creager

14. MOTHER'S MAIDEN NAME: Bettie Kitzmiller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: A. Pauline Stoner, 304 S. Church St., Waynesboro Pa.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive failure and pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Sev. days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic heart disease — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1964, to March, 1967, that I last saw the deceased alive on 3/8/67, 19, and that death occurred at 8:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard N Weeks M.D.
ADDRESS (Street, city or town, state): 580 Northern Avenue
DATE SIGNED:

PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/13/1967
22c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
22d. LOCATION (City, town, or county): Waynesboro (State): Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: S. Martin Roe
ADDRESS: Waynesboro, Penna.
24a. REC'D BY REGISTRAR DATE: MAR 14 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director; page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04274

CERTIFICATE OF DEATH

04276

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Rural Boonsboro
d. STREET ADDRESS: Rfd. 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

21-1

79

3. NAME OF DECEASED (Type or print): First: Iona — Middle: Katherine — Last: Creager

4. DATE OF DEATH: Month: March — Day: 23, — Year: 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	MARRIED [X]	Oct. 9, 1922	44 yrs.	5 / 14	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	San Mar, Wash. Co., Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Perry C. Green	Cora M. Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No.	219-12-1127	Mr. Charles W. Creager, Boonsboro Rfd.1, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cancer of cervix Metastases	one year
DUE TO (b)	Uremia due to obstruction Ureters	March 9-67
DUE TO (c)	Hypertensive C. V. Disease	

171X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia

2

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 11 1967, to March 23, 1967, that (I) (we) last saw the deceased alive on 3-22 19 67 and that death occurred at 4:05 AM, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22b. DATE SIGNED
Sidney Rovenstein		3-23-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
SIDNEY ROVENSTEIN	FUNKSTOWN MD

1

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3-25-67	Myersville EUB. Cemetery	Myersville, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.	MAR 28 1967	Beverly Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04275 — 04277

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HANCOCK
c. LENGTH OF STAY IN 1b: 38 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 136 WEST HIGH STREET

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HANCOCK
d. STREET ADDRESS: 136 WEST HIGH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

21-1

3. NAME OF DECEASED (Type or print): First PRESTON Middle ELWOOD Last CROUSE

4. DATE OF DEATH: Month MARCH Day 7, Year 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/17/1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: PETROLEUM SALES
11. BIRTHPLACE (County & State, or foreign country): MORGAN CO., W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ASBURY HOUSTON CROUSE
14. MOTHER'S MAIDEN NAME: CATHERINE VIRGINIA SOTTLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES
(If yes give war or dates of service): W.W. 1
16. SOCIAL SECURITY NO.: 212-03-8595
17. INFORMANT: ETHEL O. CROUSE — Address: 136 W. HIGH STREET HANCOCK, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Infarct
DUE TO (b): Pulmonary Edema
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/7, 19 67, to 12/7, 19 67 that (I) (we) last saw the deceased alive on ____ 19____, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: L.M. Shaffer M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): L.M. SHAFFER M.D.
22d. ADDRESS: MAIN STREET, HANCOCK, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/10/67
23c. NAME OF CEMETERY OR CREMATORY: OAKLAND METHODIST
23d. LOCATION (City, town or county) (State): MORGAN CO., WEST VIRGINIA

24. FUNERAL DIRECTOR: Howard J. Hyde — ADDRESS: Hancock Md.
25a. REC'D BY REGISTRAR (DATE): MAR 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04276 — 04278

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give name of town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 45 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 200B HAYES AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SARAH — Middle ELIZABETH — Last CUSTER
4. DATE OF DEATH: Month MARCH — Day 23 — Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 6/20/1894
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: MORGAN PRICE
14. MOTHER'S MAIDEN NAME: SUAN BREEDEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 214-09-1133
17. INFORMANT: MR. JOSEPH W. CUSTER — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
331X
IMMEDIATE CAUSE (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Cerebral Arteriosclerosis — Indefinite
DUE TO (c): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Previous cerebral accident. Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-26, 1967 to death, 19___, that (I) (we) last saw the deceased alive on 3-18, 1967, and that death occurred at 1:30 p.m. from causes and on the date stated above.

22a. SIGNATURE: Robert F. Keadle M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: 3-24-67
22c. PHYSICIAN'S NAME (Type): Robert F. Keadle, M. D.
22d. ADDRESS: Hagerstown, Md. 21740

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/27/67
23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
23d. LOCATION (City or Town) (County) (State): HAGERSTOWN WASH. MD.

24. FUNERAL DIRECTOR — ADDRESS: W. T. Norment, Hagerstown Md.
25a. REC'D BY REGISTRAR DATE: MAR 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jorgo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04277 04279

1. PLACE OF DEATH
a. COUNTY: Washington MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 1719 Homewood Road

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Hagerstown 21.1
d. STREET ADDRESS: 1719 Homewood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Francis Lost Davis
4. DATE OF DEATH: Month March Doy 25 Year 19 67
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 31, 1904
9. AGE (In yeors lost birthday): 62 yrs.
IF UNDER 1 YEAR: Months Doys
IF UNDER 24 HRS.: Hours Min.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal
10b. KIND OF BUSINESS OR INDUSTRY: Dust Col. Mfg.
11. BIRTHPLACE (State or foreign country): Washington Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John R. Davis
14. MOTHER'S MAIDEN NAME: Bessie Huffer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 214-09-6138
17. INFORMANT: Mrs. Goldie Davis Address: 1719 Homewood Rd. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
4201
DUE TO
Conditions, if any, which gove rise to immediote couse (o), stoting the underlying couse last.
(b): athrosclerotic coronary artery disease — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took chorge of the remoins described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, ond in my opinion deoth resulted from: Naturol couses ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.
EXAMINER'S NAME (Type): Howard N. Weeks, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 3/28/67
Address (Street, city, town, or county): 580 Northern Ave. Hagerstown, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/29/67
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown, Washington, Md.
24. FUNERAL DIRECTOR: Wm. A. Hurst ADDRESS: Rest Haven Funeral Chapel Hagerstown, Md.
25o. REC'D BY REGISTRAR DATE: MAR 30 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04278 04280

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 45 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 335 S. CANNON AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALFREDO Middle N.M.N. Last DeFELICE

4. DATE OF DEATH: Month MARCH Day 9 Year 19 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 29,1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TURBINE TENDER
10b. KIND OF BUSINESS OR INDUSTRY: CEMENT PLANT
11. BIRTHPLACE (County & State, or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH DeFELICE
14. MOTHER'S MAIDEN NAME: GIUANNA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) ----------
16. SOCIAL SECURITY NO. 213-10-6785
17. INFORMANT: MRS. EVA DeFELICE Address: 335 S. CANNON AVE. HAGERSTOWN, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Biliary Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 3 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Ruptured Gall Bladder — 3 day
DUE TO
(c):
586X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/12, 1967 to 3/9/67, 19___, that (I) (we) last saw the deceased alive on 3/9/67 19___, and that death occurred at 7:50 PM, from causes and on the date stated above.

22a. SIGNATURE: Lawrence L Packer Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/10/67
22c. PHYSICIAN'S NAME (Type): LAWRENCE L. PACKER, JR. M.D.
22d. ADDRESS: 145 W. WASHINGTON ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MARCH 13,1967
23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY
23d. LOCATION (City or Town) (County) (State): HAGERSTOWN, MARYLAND

24. FUNERAL DIRECTOR: CHARLES M. ROUZER ADDRESS: HAGERSTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAR 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04279

CERTIFICATE OF DEATH

04281

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21.1
d. STREET ADDRESS: 2231 Jefferson Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: John — Middle: Calvin — Last: Deibert

4. **DATE OF DEATH**: Month: March — Day: 18, — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 13,1901

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): fireman

10b. KIND OF BUSINESS OR INDUSTRY: furniture Mfg.

11. BIRTHPLACE (County & State, or foreign country): Cavetown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hezekiah W. Deibert

14. MOTHER'S MAIDEN NAME: Mary Ann Burger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-7287

17. INFORMANT — Address: Hazel Ecton, Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minuts
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension Essential

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from October 11, 1959 to death 19__, that (I) (we) last saw the deceased alive on 3-18 1967, and that death occurred at 9:04 A.M., from causes and on the date stated above.

22a. SIGNATURE: Robert F. Keadle M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-20 67

22c. PHYSICIAN'S NAME (Type): Robert F. Keadle, M. D.

22d. ADDRESS: Hagerstown, Md. 21740

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-21-67

23c. NAME OF CEMETERY OR CREMATORY: Cavetown Cemetery

23d. LOCATION (City or Town) (County) (State): Cavetown, Md.

24. FUNERAL DIRECTOR: Minnich Funeral Home, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0#280

CERTIFICATE OF DEATH

04282

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) Garlock Mem. Conv. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Penna. b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle, Pa. 75-3
d. STREET ADDRESS 36 W. Balto. St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MARTHA Middle F. Lost DETRICH
4. DATE OF DEATH Month 3 Day 19 Year 1967 19
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 7/5/1868
9. AGE (In years last birthday) 98 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel G. Hollinger
14. MOTHER'S MAIDEN NAME Elizabeth FUNK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mary E. Detrich Address Greencastle, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4221
IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Several years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardio Vascular Disease
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from 3-17- , 19 67, to 3-19- , 1967, that (I) (we) last saw the deceased alive on 3-19- 19 67, and that death accurred at 5:10 P.M. from causes and on the date stated abave.

22a. SIGNATURE E. W. Ditto
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 3-20-67
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.
22d. ADDRESS 215 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) B
23b. DATE THEREOF 3/22/67
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill
23d. LOCATION (City or Town) (County) (State) Greencastle, Pa.
24. FUNERAL DIRECTOR C. E. Wenrich ADDRESS Greencastle, Pa.
25a. REC'D BY REGISTRAR DATE MAR 22 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04281 04283

FOR STATE HEALTH DEPT

1. PLACE OF DEATH
a. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN 21-1
d. STREET ADDRESS: 1212 W. WASHINGTON ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle M. Last DIETZ
4. DATE OF DEATH: Month MARCH Day 10 Year 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/5/1880
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: CLAGGETT W. RANDALL
14. MOTHER'S MAIDEN NAME: SARAH JOHNSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 214-09-9358
17. INFORMANT: MR. HARRY C. RANDALL Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia Secondary 9020
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): to Fracture of Femur
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell when getting into bed at Home.
20c. TIME OF INJURY Month, Day, Year: Hour 10 a.m. p.m. 10-30 1966
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Hagerstown (County) Wash (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐
ACTUAL SIGNATURE: Edward W. Ditto III M.D.
EXAMINER'S NAME (Type): Edward W. Ditto III
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county): 212 W. Washington St Hagerstown, Md
22. DATE SIGNED: 3-11-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/13/67
23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
23d. LOCATION (City or Town) (County) (State): HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR: W. T. Norment ADDRESS: Hagerstown, Md.
25. REC'D BY REGISTRAR DATE: MAR 14 1967
26. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04282

CERTIFICATE OF DEATH

04284

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: WASHINGTON — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN c. LENGTH OF STAY IN 1b: 65 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN 21-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): WASHINGTON COUNTY HOSPITAL	d. STREET ADDRESS: 1707 OAK HILL AVENUE e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: JOHN	Middle: CARL	Last: DITMER	4. DATE OF DEATH	Month: MARCH Day: 10 Year: 19 67
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: DEC. 13,1891	9. AGE (In years last birthday): 75 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SHEET METAL WORKER	10b. KIND OF BUSINESS OR INDUSTRY: AIRCRAFT	11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND CO., PENNA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: EDWARD DITMER		14. MOTHER'S MAIDEN NAME: EMMA KUNKLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): ----------	16. SOCIAL SECURITY NO.: 214-09-7381A	17. INFORMANT: MRS. WILMER MOSS	Address: 1707 OAK HILL AVE. HAGERSTOWN, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma - Rt. frontal sinus — INTERVAL BETWEEN ONSET AND DEATH: 8 mo.
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

1607

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Feb. , 19 67, to Mar 10 , 1967, that (I) ~~(we)~~ last saw the deceased alive an Mar. 10 1967, and that death occurred at 6 P M, from causes and on the date stated above.

22a. SIGNATURE: Lloyd A. Hoffman M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 3/11/67	
22c. PHYSICIAN'S NAME (Type): LLOYD A. HOFFMAN M.D.		22d. ADDRESS: 214 N. POTOMAC STREET HAG., MARYLAND	

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: MARCH 13,1967	23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State): HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR: CHARLES M. ROUZER	ADDRESS: HAGERSTOWN, MARYLAND	25a. REC'D BY REGISTRAR DATE: MAR 15 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04283 04285

1. PLACE OF DEATH
a. COUNTY: WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN 21-1
d. STREET ADDRESS: 61 NORTH AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle GRACE Last DOWNIN

4. DATE OF DEATH: Month MARCH Day 20 Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 9 1879

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED TEACHER

10b. KIND OF BUSINESS OR INDUSTRY: EDUCATION

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: C GEORGE BORYER

14. MOTHER'S MAIDEN NAME: MARGARET GARMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MARGARET B GAINES LAGUNA HILLS CALIF.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO (b): Myocardial Infarction — 16 days
DUE TO (c): Arteriosclerosis — Gen. — yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July, 1939, to Mar - 20, 1967, that (I) (~~we~~) last saw the deceased alive on Mar - 20 1967, and that death occurred at 11:05A M, from causes and on the date stated above.

22a. SIGNATURE: Lloyd A. Hoffman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/21/67

22c. PHYSICIAN'S NAME (Type): LLOYD A HOFFMAN M.D.

22d. ADDRESS: 214 N. POTOMAC ST. HAGERSTOWN MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3/23/67

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City or Town) (County) (State): HAGERSTOWN WASHINGTON MD.

24. FUNERAL DIRECTOR: CHARLES M ROUZER ADDRESS: HAGERSTOWN MARYLAND

25a. REC'D BY REGISTRAR: MAR 28 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04284 04286

1. PLACE OF DEATH
a. COUNTY: Washington — Hagerstown MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD2, Smithburg Md. 21-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: Virginia — Last: Draper

4. DATE OF DEATH: Month: March — Day: 29, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 6,1905

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Ira Grove

14. MOTHER'S MAIDEN NAME: Anna Barbara Renner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: James T. Draper Sr. RFD2, Smithburg.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus, Massive — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Thrombosis of Femoral and iliac veins — 2 days ?
DUE TO (c): Intracranial hemorrhage (intracerebral) with hemiplegia — 5 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension, Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 26, 19 67 to March 29, 19 67, that (I) (we) last saw the deceased alive on March 29 19 67, and that death occurred at 10:05AM, from the causes and on the date stated above.

22a. SIGNATURE: Archie Robert Cohen — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: March 30, 1967

22c. PHYSICIAN'S NAME (Type): Archie Robert Cohen, M.D.

22d. ADDRESS: Clear Spring, Maryland 21722

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 1, 67

23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery

23d. LOCATION (City, town or county) (State): Clear Spring, Maryland

24. FUNERAL DIRECTOR: Donald E. Thompson

ADDRESS: Clear Spring, Md.

25a. REC'D BY REGISTRAR: MAR 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04285 04287

1. PLACE OF DEATH
a. COUNTY: Washington MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Rural Clear Spring, Md.
c. LENGTH OF STAY IN 1b: 8 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural Clear Spring, Md.

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest fawn): Rural Clear Spring, Md.
d. STREET ADDRESS: Rural Clear Spring, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Ignatious	Samuel	Drury	Mar.	5,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Haurs / Min.
Male	White	MARRIED ☒	Oct. 7, 1891	75 yrs.		

10a. USUAL OCCUPATION (Give kind af wark dane during most of warking life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (Caunty & State, ar foreign cauntry)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Franklin Co. Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Martin Luther Drury	Ellen Britton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war ar dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No None	219-01-8219	Mrs Annie Drury Clear Spring, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO (b): Arteriosclerosis — 10 yrs
DUE TO (c):
Conditians, if any, which gave rise ta immediate cause (a), stoting the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I or Port II af item 1B.)
20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at wark ☐
20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)
20f. (City ar town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 11-2, 1967, ta 3-6, 1967, that (I) (we) last saw the deceased alive an 2-20 1967, and that death accurred at 10:30 M, fram causes and an the date stated above.

22a. SIGNATURE: M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 6, 1967
22c. PHYSICIAN'S NAME (Type): Dr. M. E. Byrkit, M. D.
22d. ADDRESS: 28 W Potomac St. Williamsport, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3/8/67	Pinesburg Mennonite	Clear Spring, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Margaret Rowland Clear Spring, Md.	MAR 10 1967	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04286 04288

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
c. LENGTH OF STAY IN 1b: 18 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Avalon Manor

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Penna — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chambersburg R5-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Newton — Middle I — Last Eshelman

4. **DATE OF DEATH**: Month 3 — Day 8 — Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 27, 1901

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Refuse Collector

10b. KIND OF BUSINESS OR INDUSTRY: Trucking

11. BIRTHPLACE (County & State, or foreign country): Franklin Co, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Isaac G. Eshelman

14. MOTHER'S MAIDEN NAME: Mary Wolford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 195-28-0445

17. INFORMANT: Mrs Della R. Eshelman — Address: R1 Chambersburg, Pa.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 Wks.
332X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis - Generalized — 1yr. +
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Feb. 19, 1967 to 3-8, 1967, that (I) (~~we~~) last saw the deceased alive on 3/8 19 67, and that death occured at 12 N from the causes and on the date stated above.

22a. SIGNATURE: Lloyd A. Hoffman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/11/67

22c. PHYSICIAN'S NAME (Type): Lloyd A- HoFFman

22d. ADDRESS: 214 N. Potomac st. Hagerstown, md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/11/67

23c. NAME OF CEMETERY OR CREMATORY: Fetterhoff Chapel Cemetery

23d. LOCATION (City, town or county) (State): Franklin Penna

24. FUNERAL DIRECTOR'S SIGNATURE: Robert R. Barbour — ADDRESS: Chambersburg, Pa.

REC'D BY REGISTRAR DATE: MAR 14 1967

REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04287 — 04289

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: WASHINGTON — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN MD. — c. LENGTH OF STAY IN 1b: 2 WKS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HANCOCK 21-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL	d. STREET ADDRESS: 217 DALE ST. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ELMER	WILLIAM	FLOWERS	3	10	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	MARRIED ☒	6.1.1900	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FORMAN,	SOUTHERN PIPE LINE CO.	WASHINGTON COUNTY MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ALBERT FLOWERS	ANNIE FISHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	203.07.6454	MARY M FLOWERS 217 DALE ST. HANCOCK MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO (b): Nephrosclerosis — 4 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Cardiov. Dis. — yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hepatomegaly. Bronchitis, emphysema. ? Myeloma — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 27 Feb, 19__, to 10 Mar, 19 67, that (I) (we) last saw the deceased alive on 10 Mar 19 67, and that death occurred at 8P M, from causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS.	22b. DATE SIGNED
Richard T. Binford M.D.	☒ / ☐ / ☐	13 Mar 67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Richard T. Binford, M. D.	1135 Potomac Avenue Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	3.13.67	ROGHER HEIGHTS	RURAL HANCOCK WASHINGTON MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Howard J Stone Hancock Md	MAR 15 1967	J Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04288

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04290

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILLIAMSPORT 21-1
d. STREET ADDRESS: 31 E. CHURCH ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

79

3. NAME OF DECEASED (Type or print): First: EUGENIA — Middle: MARIE — Last: GLADHILL
4. DATE OF DEATH: Month: MARCH — Day: 16 — Year: 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/3/1963
9. AGE (In years last birthday): 3 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROLLAND E. GLADHILL
14. MOTHER'S MAIDEN NAME: PATRICA MEADE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. PATRICA M. GLADHILL — Address: WILLIAMSPORT MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Comminuted Expressed Fracture Skull Left — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO
(b): Parietal With Brain Laceration & Intra-
DUE TO
(c): cranial Hemorrhage.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

8164 ✓

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in car which was in head on collision.
20c. TIME OF INJURY Month, Day, Year Hour: 3:05 p.m. 3-16- 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): State R# 68
20f. (City or town) Williamsport (County) Washington (State) Md.

21

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: N. W. Ditto M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 3-17-67
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.
Address (Street, city, town, or county): Hagerstown, Md.

2

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/18/67
23c. NAME OF CEMETERY OR CREMATORY: CEDAR LAWN MEM. GARDENS
23d. LOCATION (City or Town) HAGERSTOWN (County) (State) MD.

24. FUNERAL DIRECTOR: W. J. Norment — ADDRESS: Hagerstown, Md.
25a. REC'D BY REGISTRAR: MAR 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yeager

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04289 04291

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garlock Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 30 Cottage Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle EDWARD — Last GROSSNICKLE
4. DATE OF DEATH: Month March — Day 10, — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 1, 1877
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Landis Tool Co.
11. BIRTHPLACE (County & State, or foreign country): Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leonard Grossnickle
14. MOTHER'S MAIDEN NAME: Mary Renner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): *****
16. SOCIAL SECURITY NO.:
17. INFORMANT: Kenneth Grossnickle, Address: Fayetteville, Pennsylvania.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
4500
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Advanced Arteriosclerosis, generalized — 25 yrs
DUE TO (c): Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Prostate hypertrophy, Benign. Hypochromic Anemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 3-4-, 1967, to 3-10-, 1962, that (I) ~~(we)~~ last saw the deceased alive on 3-4- 1967, and that death occurred at 12:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edward W. DiHo III, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-10-67
22c. PHYSICIAN'S NAME (Type): Edward W. DiHo III, M.D.
22d. ADDRESS: 217 W. Washington St Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/12/67
23c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
23d. LOCATION (City, town or county) (State): Middletown, Fred.Co.Md.

24. FUNERAL DIRECTOR — ADDRESS: Gladhill Company, Middletown, Maryland
25a. REC'D BY REGISTRAR (Date): MAR 1 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04290

CERTIFICATE OF DEATH

04292

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 /Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 17 Public Square
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA — Middle LORRAINE — Last GUESSFORD

4. DATE OF DEATH: Month March — Day 26 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jany 10 1902

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stitcher

10b. KIND OF BUSINESS OR INDUSTRY: Shoe Co

11. BIRTHPLACE (County & State, or foreign country): Parkersburg W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Leonidas Roane

14. MOTHER'S MAIDEN NAME: Bessie (No Record)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service): -----

16. SOCIAL SECURITY NO.: 214-09-9180
214-09-7230D

17. INFORMANT — Address: James R. Middlekauff 210 Hagesr St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolus — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO (b): Posterior Coronary ischemia — 3 weeks
DUE TO (c): Arterio sclerosis, Generalized — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonia. Hepatic cirhosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/21, 1967, to 3/26, 1967, that (I) (we) last saw the deceased alive on 3/25 1967, and that death occurred at 6:45 AM, from causes and on the date stated above.

22a. SIGNATURE: Geo. Hennings — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): George Hennings

22d. ADDRESS: 315 N. Potomac St Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/28/67

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown, Maryland

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc. — ADDRESS: Hagerstown, Maryland

25a. REC'D BY REGISTRAR: MAR 30 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04291 **CERTIFICATE OF DEATH** 04293

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 22 W. Potomac Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d. STREET ADDRESS: 22 W. Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
David	Mc Kendree	Harsh	March	23	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		Feb.. 24 1883	84 yrs.	0	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bar Tender	Tavern	Williamsport Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David H. Harsh	Malinda Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	-----	219-12-0501	Miss. Louise Harsh	22 W. Potomac St.. Williamsport Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infardion — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Atherosclerosis — 10 yrs
DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 19 65 to 3-22 19 67, that (I) (we) last saw the deceased alive on 3-23 1967, and that death occurred at 3:30 A M, from the causes and on the date stated above.

22a. SIGNATURE: M.E. Byrkit — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3-23-67

22c. PHYSICIAN'S NAME (Type): M.E. Byrkit — 22d. ADDRESS: Williamsport Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	March 25-67	Rest Haven Cemetery	Hagerstown Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Albert L. Leaf Williamsport Md.	MAR 27 1967	J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04292 04294

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 10 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 1016 POTOMAC AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: LEDBETTER — Lost: HEGELER

4. DATE OF DEATH: Month: MARCH — Doy: 15 — Year: 19 67

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 22, 1913
9. AGE (In yeors last birthdoy): 53 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY
10b. KIND OF BUSINESS OR INDUSTRY: MINING CORP.
11. BIRTHPLACE (County & State, or foreign country): CALHOUN CO., ALABAMA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EMMETT W. LEDBETTER
14. MOTHER'S MAIDEN NAME: JESSIE JONES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service): ----------
16. SOCIAL SECURITY NO.: 111-22-7311
17. INFORMANT: MR. H. HARTLEY HEGELER — Address: 1016 POTOMAC AVE. HAGERSTOWN, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs.
DUE TO
(b): Coronary Thrombosis — 18 hrs.
DUE TO
(c): Arterio sclerotic Heart Disease — 5 mo.
4201
Conditions, if ony, which gave rise to immediote couse (o), stoting the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May, 1957, to Mar. 15, 1967 that (I) (we) last saw the deceased alive on March 15 1967, and that death occurred at 4:15 A.M., from causes and on the date stated above.

22o. SIGNATURE: Lloyd A. Hoffman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/17/67
22c. PHYSICIAN'S NAME (Type): LLOYD A. HOFFMAN M.D.
22d. ADDRESS: 214 N. POTOMAC ST. HAGERSTOWN, MD.

23o. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 3/17/1967
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY
23d. LOCATION (City or Town) (County) (State): WASHINGTON D.C.

24. FUNERAL DIRECTOR: CHARLES M. ROUZER — ADDRESS: HAGERSTOWN, MARYLAND
25o. REC'D BY REGISTRAR DATE: MAR 20 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04295

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: 115 John St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2.1

3. **NAME OF DECEASED** (Type or print): First: Norman — Middle: Nelson — Last: Heller

4. **DATE OF DEATH**: Month: March — Day: 25, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 17, 1917

9. AGE (In years lost birthday): 49 yrs.

IF UNDER 1 YEAR: Months: 3 — Days: 8

IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sign Painter

10b. KIND OF BUSINESS OR INDUSTRY: Painting

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Nelson Heller

14. MOTHER'S MAIDEN NAME: Ruth Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give wor or dates of service): W. W. Two

16. SOCIAL SECURITY NO.: 212-14-7245

17. **INFORMANT**: Mrs. E. Rebecca Heller, 115 John St. — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4201

IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stoting the underlying couse last.

(b): — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(c): — INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Advanced cirrhosis of the liver

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.

EXAMINER'S NAME (Type): Howard N. Weeks, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 3/27/67

Address (Street, city, town, or county): 580 Northern Ave. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3- 28- 67

23c. NAME OF CEMETERY OR CREMATORY: Benevola Cemetery

23d. LOCATION (City or Town) (County) (State): Benevola, Md.

24. FUNERAL DIRECTOR — ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.

25a. REC'D BY REGISTRAR — DATE: MAR 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04294 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04296

1. PLACE OF DEATH
a. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN 21-1
d. STREET ADDRESS: 2014 GAY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

79

3. NAME OF DECEASED (Type or print): First JOHN Middle STUART Last HESS
4. DATE OF DEATH: Month MARCH Day 14 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCT 10,1901
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. TERMINAL MGR.
10b. KIND OF BUSINESS OR INDUSTRY: TRUCKING CO.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: MAURICE HESS
14. MOTHER'S MAIDEN NAME: MARGARET SCHLEIGH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 214-10-4681
17. INFORMANT: MRS. BERTIE HESS Address: 2014 GAY STREET HAGERSTOWN MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: Several days
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Fracture Of Right 5th. & 6th. Ribs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): A Possible Terminal Thrombotic Occlusion Of Anterior Descending
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Coronary Artery. Evidently fell in home.
20c. TIME OF INJURY Month, Day, Year Hour a.m.: Possibly a.m. 3-11- 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Hagerstown, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward W. Ditto Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
M.O. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 3-17-67
EXAMINER'S NAME (Type): EDWARD W. DITTO, JR. M.D. Address (Street, city, town, or county): 215 W. WASH. ST HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MARCH 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY
23d. LOCATION (City, town or county) (State): HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR: CHARLES M. ROUZER ADDRESS: HAGERSTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAR 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04295 04297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b:
   d. NAME DF HOSPITAL OR INSTITUTIDN (If not in hospitol, give street oddress): Avalon Manor

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Hagerstown
   d. STREET ADDRESS: 1011 Oak Hill Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME DF DECEASED** (Type or print): First: George — Middle: Harlan — Lost: Hornbaker

4. **DATE OF DEATH**: Month: March — Doy: 27 — Year: 1967

5. SEX: Male

6. COLDR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 21, 1884

9. AGE (In yeors last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Division Eng.

10b. KIND OF BUSINESS OR INDUSTRY: W. M. Rwy. Co.

11. BIRTHPLACE (County & Stote, or foreign country): Mercersburg, Franklin Co

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Hornbaker

14. MOTHER'S MAIDEN NAME: Penna Jane E. Shatzer

15. WAS DECEASED EVER IN U.S. ARMED FDRCES? (Yes, no, or unknown): no — (If yes give wor or dotes of service): no

16. SOCIAL SECURITY NO.: A482822

17. **INFORMANT** Address: Dr. John H. Hornbaker, 1117 Oak Hill Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Metastatic Sarcoma — to Stomach — INTERVAL BETWEEN ONSET AND DEATH: 7 mo.
DUE TO
(b): Retroperitoneal Lympho Sarcoma - — 1 yr.
Conditions, if any, which gave rise to immediate couse (o), stoting the underlying couse lost.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Feb 11, 1967, to Mar. 27, 1967, that (I) (~~we~~) last saw the deceased alive an Mar. 27 1967, and that death accurred at 4 P M, fram causes and an the date stated abave.

22a. SIGNATURE: Lloyd A. Hoffman — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/27/67

22c. PHYSICIAN'S NAME (Type): Lloyd A. HOFFman

22d. ADDRESS: 214 N. Pot. st. Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 3/28/67

23c. NAME DF CEMETERY OR CREMATDRY: Green Mount Crematory

23d. LOCATION (City or Town) (County) (Stote): Baltimore, Md.

24. FUNERAL DIRECTDR ADDRESS: Andrew K. Coffman Funeral Home, Inc. Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 30 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04296 — 04298

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Mon.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: 504 Valley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

3. NAME OF DECEASED (Type or print): First: Mildred — Middle: Claire — Last: Houchin
4. DATE OF DEATH: Month: March — Day: 24 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 12-1908
9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: State&PublicSchools
11. BIRTHPLACE (County & State, or foreign country): Fulton- Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Lewis Houchin
14. MOTHER'S MAIDEN NAME: Lennie Blanche Sims
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dates of service): ———
16. SOCIAL SECURITY NO.: Not Available — 219-36-4970
17. INFORMANT: Mrs. Wm. B. Gross — Address: Brunswick, Md. 304 Central Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH
170X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma left breast — 1 ½ yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II af item 1B.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Hame, farm, factory, street, affice bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Oct 10, 1966, to March 24, 1967, that (I) (we) last saw the deceased alive on March 24, 1967, and that death accurred at A. M, fram causes and on the date stated abave.

22a. SIGNATURE: John A. Moran M. D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 24-1967
22c. PHYSICIAN'S NAME (Type): JOHN A. MORAN M.D.
22d. ADDRESS: 215 W. Washington St, Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3- 28- 1967
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
23d. LOCATION (City or Town) (County) (State): Fulton- Missouri 65251
24. FUNERAL DIRECTOR: M.R.Etchison & Son — ADDRESS: Elwood T. Frederick, Md. 21701 — Wilkinson
25a. REC'D BY REGISTRAR: MAR 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04297

CERTIFICATE OF DEATH

04299

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Boonsboro
   c. LENGTH OF STAY IN 1b: 6 Years
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Fahrney-Keedy Memorial Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution, residence before admission)
   a. STATE: D.C. — b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
   d. STREET ADDRESS: 3601 Connecticut Ave., N.W.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Araminta — Middle: — Last: Howell

4. **DATE OF DEATH**: Month: March — Day: 28 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 28, 1877

9. AGE (In years last birthday): 89 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Berryville, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howell, James Franklin

14. MOTHER'S MAIDEN NAME: Kerchival, Emma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3y
DUE TO (b): bacl pneumonitis — 2wks
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible] to March 28, 1967 that (I) (we) last saw the deceased alive on 10:15 a.m. 3-28-67 and that death occurred at 10:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: G. W. LeVan, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): G. W. LeVan

22d. ADDRESS: Boonsboro Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 3-31-1967

23c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery

23d. LOCATION (City, town or county) (State): Berryville, Va.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.

25a. REC'D BY REGISTRAR DATE: MAR 31 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04298 **CERTIFICATE OF DEATH** 04300

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Williamsport
   c. LENGTH OF STAY IN 1b: 37 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 24 E. Salisbury Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
   d. STREET ADDRESS: 24 E. Salisbury St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gladys — Middle: Kumler — Last: Huddle

4. DATE OF DEATH: Month: March — Day: 30 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 31 1898

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months: 11 Days: 24 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: David C Kumler

14. MOTHER'S MAIDEN NAME: Myrtle Fout

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service): ------

16. SOCIAL SECURITY NO.: 218 30 9721B

17. INFORMANT: Rev. William C. Huddle — Address: 24 E. Salisbury St.. Williamsport Md..

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Atherosclerosis — 5 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~this hospital~~ attended the deceased from Nov 10, 1958, to Mar 30, 1967, that (I) ~~we~~ last saw the deceased alive on Feb 27 1967, and that death occurred at 12:15 PM from the causes and on the date stated above.

22a. SIGNATURE: M. E. Byrkit M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Mar 31 1967

22c. PHYSICIAN'S NAME (Type): M. E. Byrkit

22d. ADDRESS: Williamsport Maryland 21795

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 1-67

23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

23d. LOCATION (City, town or county) (State): Williamsport Maryland

24. FUNERAL DIRECTOR — ADDRESS: Mr. Albert L. Leaf Williamsport Md.

25a. RECD BY REGISTRAR DATE: APR 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04299 04301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 month
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Friendship Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1931 Lincolnshire Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: William — Last: Huff

4. DATE OF DEATH: Month: March — Day: 13 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 24 1903

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months: 3 Days: 19 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Buildings

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Thomas Huff

14. MOTHER'S MAIDEN NAME: Annie Cullison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 214-09-9758

17. INFORMANT: Mrs. Blanche D Huff — Address: 1931 Lincolnshire Road Hagerstown Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hypertensive Arteriosclerotic Vascular Disease, Severe	5 years
DUE TO (b)	Hemiplegia	3 years
DUE TO (c)		

447X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-1- , 19 66, to 3-13- , 19 67, that (I) (we) last saw the deceased alive on 2-18- 1967, and that death occurred at 4 AM, from the causes and on the date stated above.

22a. SIGNATURE: E. W. Ditto M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-13-67

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.

22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 15-67

23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

23d. LOCATION (City, town or county) (State): Williamsport Maryland

24. FUNERAL DIRECTOR — ADDRESS: Albert L. Leaf Williamsport Md.

25a. REC'D BY REGISTRAR DATE: MAR 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04300

CERTIFICATE OF DEATH

04302

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 6 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Wash.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg rural 21-1
   d. STREET ADDRESS: RFD #2
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Simon — Middle: Verdene — Last: Huntsberry

4. **DATE OF DEATH**: Month: Mar. — Day: 1 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 23, 1909

9. AGE (In years last birthday): 57 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Truck Farmer

11. BIRTHPLACE (County & State, or foreign country): Pondsville, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles C. Huntsberry

14. MOTHER'S MAIDEN NAME: Mrs. Onie Bear

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-09-9564

17. **INFORMANT**: Richard C. Huntsberry — Address: RD#2, Smithsburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary embolism	2 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Phlebothrombosis	1 month
DUE TO (c)	Hypertensive cardiovascular disease	10 years

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9-27, 1954, to 3-1, 1967, that (I) (we) last saw the deceased alive on 2-28-1967, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Charles F. Hess M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3-2-67

22c. PHYSICIAN'S NAME (Type): Charles F. Hess, M.D.

22d. ADDRESS: Smithsburg, Maryland 21783

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar. 4, 1967

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

23d. LOCATION (City, town or county) (State): Smithsburg Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Minnich Funeral Home, Smithsburg, Md.

25e. REC'D BY REGISTRAR — DATE: MAR 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04301

CERTIFICATE OF DEATH

04303

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): Garlock Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Hagerstown
d. STREET ADDRESS: 815 Antietam Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Effa — Middle: Dora — Last: Hykes

4. DATE OF DEATH: Manth: March — Day: 1, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 5, 1881

9. AGE (In years last birthdoy): 85 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind af wark dane during most af warking life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, ar fareign country): Mason-Dixon Wash. Co. Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George W. Shubert

14. MOTHER'S MAIDEN NAME: Alice Boward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 214-48-3791

17. INFORMANT: Charles S. Hykes Jr. — Address: 815 Antietam Dr. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): atherosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II af item 18.)

20c. TIME OF INJURY Manth, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)

20f. (City ar tawn) (Caunty) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-27, 1967, to 3-1, 1967, that (I) (we) last saw the deceased alive an 2-27 1967, and that death accurred at 12:40 M, from causes and on the date stated above.

22a. SIGNATURE: A.M. Mandell M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-1-67

22c. PHYSICIAN'S NAME (Type): A.M. Mandell M.D.

22d. ADDRESS: 119 East Antietam Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/3/67

23c. NAME OF CEMETERY OR CREMATORY: Dunkard Cemetery

23d. LOCATION (City ar Tawn) (County) (State): Broadforing, Wash. Co. Md.

24. FUNERAL DIRECTOR: Andrew K. Coffman — ADDRESS: Andrew K. Coffman Funeral Home Inc. Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judy

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04302 04304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremotion, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside carporate limits, write RURAL ond give neorest tawn): Hagerstown
   c. LENGTH OF STAY IN 1b: 1 year
   d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospitol, give street oddress): 316 N. Mulberry St.

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Washington — b. COUNTY: Maryland
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn): Hagerstown
   d. STREET ADDRESS: 316 N. Mulberry St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type ar print): First: Grant — Middle: S. — Lost: Imboden

4. **DATE OF DEATH**: Month: March — Doy: 17, — Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 26, 1903

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): painter

10b. KIND OF BUSINESS OR INDUSTRY: painting

11. BIRTHPLACE (County & Stote, or foreign country): Annville, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isaac Imboden

14. MOTHER'S MAIDEN NAME: Sarah Shenk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown): no (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 143-03-1091

17. **INFORMANT** Address: A Kreamer Funeral Home Annville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of rectum c metastasis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
154X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture af injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Hame, form, factory, street, office bldg., etc.)

20f. (City or tawn) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 1/4, 1967, to 3/17, 1967, that (I) (we) last saw the deceased alive an 3/2, 1967, and that death accurred at 10:30 A.M., from causes and an the date stated above.

22a. SIGNATURE: Geo. Jennings — ATTENDING PHYS. M.D. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/17/67.

22c. PHYSICIAN'S NAME (Type): Dr. George Jennings

22d. ADDRESS: Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-18-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. Annville Cemetery

23d. LOCATION (City or Tawn) (County) (State): Annville, Pa.

24. FUNERAL DIRECTOR ADDRESS: Minnich Funeral Home, Hagerstown, Md.

26a. REC'D BY REGISTRAR DATE: MAR 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04303

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04305

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ... director. Page 4 should be ... ded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retai... or your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within ... hours after death.

VR A15ME
5M 1/62

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown Maryland
c. LENGTH OF STAY IN 1b: 60 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 159 W. Washington Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Maryland
d. STREET ADDRESS: 459 Plark Place
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ashby — Middle: (no) — Last: Jackson

4. DATE OF DEATH: Month: Mar — Day: 11 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 22 1881

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Private family

11. BIRTHPLACE (State or foreign country): Rappahannock, Va.

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Martin Jackson

14. MOTHER'S MAIDEN NAME: Jamie Grigsby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 216-14-5167

17. INFORMANT: Mrs. Kathryn G. Butler — Address: 38 N. Summit St. Harrisburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immed

4201

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: General Arteriosclerosis + Arteri... — 25 yrs

(c): Sclerotic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward W Ditto III M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-13-67

EXAMINER'S NAME (Type): Edward W. Ditto III

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-15-1967

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or country) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR — ADDRESS: John K Watson Hagerstown Md.

24a. REC'D BY REGISTRAR: MAR 15 1967

24b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04304 04306

1 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md c. LENGTH OF STAY IN 1b: 60 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Western Maryland State Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland 21-1 d. STREET ADDRESS: 456 Park Place e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Charles — Middle: Moll — Last: Jones	4. DATE OF DEATH: Month: March — Day: 13, — Year: 1967
5. SEX: Male	6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Oct. 20, 1898
9. AGE (In years lost birthday): 68 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY: Mill
11. BIRTHPLACE (County & State, or foreign country): Rippon, W.Va.	12. CITIZEN OF WHAT COUNTRY?: USA.
13. FATHER'S NAME: Thomas Jones	14. MOTHER'S MAIDEN NAME: Laura Helms
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes World War 1	16. SOCIAL SECURITY NO.: 217-10-3256
17. INFORMANT — Address: Mrs. Hattie Jones 456 Park Place.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b): bronchogenic carcinoma — 7 mos.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1-9, 1967 to 3-13, 1967, that (I) (~~we~~) last saw the deceased alive on March 13, 1967, and that death occurred at 6:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: March 14, 1967

22c. PHYSICIAN'S NAME (Type): VICTOR L. Ramos, M.D.

22d. ADDRESS: Western md. State Hospital Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3-18-1967	Rose Hill Cemetery	Hagerstown Md.

24. FUNERAL DIRECTOR — ADDRESS: John R Watson Jr. Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: MAR 20 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04305

CERTIFICATE OF DEATH

04307

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 43 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 513 W. Howard St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 513 W. Howard St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CLARENCE Middle SHARPE Last KARPER
4. DATE OF DEATH: Month March Day 13, Year 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 28, 1885
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): owner
10b. KIND OF BUSINESS OR INDUSTRY: dairy business
11. BIRTHPLACE (County & State, or foreign country): Franklin Co., Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: W. Edward Karper
14. MOTHER'S MAIDEN NAME: Della Laughlin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 220-44-6357
17. INFORMANT Address: Sharpe D. Karper, Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: Almost fatal — found dead in bed
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic (Coronary) Heart Disease — 1½ years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): myocardial infarction Oct 1965
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-23, 1951, to 3-13, 1967, that (I) (we) last saw the deceased alive on 1-23 1967, and that death occurred at 7.30 A. M, from causes and on the date stated above.

22a. SIGNATURE: John H. Hornbaker — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-13-67
22c. PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D.
22d. ADDRESS: 154 West Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3-15-67
23c. NAME OF CEMETERY OR CREMATORY: Norland Cemetery
23d. LOCATION (City or Town) (County) (State): Chambersburg, Penna.
24. FUNERAL DIRECTOR ADDRESS: Minnich Funeral Home, Hagerstown, Md.
25a. RECEIVED BY REGISTRAR DATE: MAR 16 1967
25b. REGISTRAR'S SIGNATURE: Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04306

CERTIFICATE OF DEATH

04308

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: PrinceGeorge
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 16-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Myrtle — Middle: Cleo — Last: Keefer

4. DATE OF DEATH: Month: March — Day: 20, — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 16, 1880

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Williamsport, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Ward

14. MOTHER'S MAIDEN NAME: Rebecca Keefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mrs. Christine Hope, Mt. Rainier, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): nephrosclerosis — unknown
DUE TO (c): arteriosclerosis, general — "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
446X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from May 4, 1966, to March 20, 1967, that (I) ~~(we)~~ last saw the deceased alive on March 20, 1967, and that death occurred at 7.03 PM, from causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: March 21, 1967

22c. PHYSICIAN'S NAME (Type): VICTOR L. RAMOS, M.D.

22d. ADDRESS: Western Md. State Hospital, Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-23-67

23c. NAME OF CEMETERY OR CREMATORY: Stone Bridge Breth Cem.

23d. LOCATION (City or Town) (County) (State): Millstone, Md.

24. FUNERAL DIRECTOR — ADDRESS: Minnich Funeral Home, Hagerstown, Md.

25a. REC'D BY REGISTRAR: MAR 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Junge

04308

Washington Md. Princegeorge

Hagerstown Hyattsville

Western Maryland State Hospital

Augusta Elva Keefer March 20, 67

Female White Aug. 16, 1880 86

Housewife Williamsport, Md.

Henry Ward Rebecca Keefer

no none Mrs. Christine Hope, [illegible], Md.

Uremia

Nephrosclerosis

Arteriosclerosis, general

Unknown

March 20, 67

Victor L. Ganes, M.D.

Burial 3-23-67 Stone Bridge Breth. Cem. Williamsport, Md.

Rahauser Funeral Home, Hagerstown, Md.

MAR 27 1967

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04307 04309

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R # 4
c. LENGTH OF STAY IN 1b: 11 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Salem Church Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R # 4 21-1
d. STREET ADDRESS: Salem Church Road
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First SAMUEL Middle CALVIN Last KING Jr
4. DATE OF DEATH: Month March Day 28 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 23 1904
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Mason
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Samuel C. King Sr
14. MOTHER'S MAIDEN NAME: Mary Ellen Springer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ---
16. SOCIAL SECURITY NO.: 214-09-9945
17. INFORMANT: Mrs Mary A [illegible] King Address: R#4 Hagerstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot Wound Of Head (Self Inflicted) — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b): ___
DUE TO (c): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
9 76X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Salem Church Road
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted gunshot wound of head.
20c. TIME OF INJURY Month, Day, Year, Hour a.m.: 9 [illegible] 3-28- 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Hagerstown, Washington, Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 3-30-67
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.
Address (Street, city, town, or county): Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/31/67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md
24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc ADDRESS: Hagerstown Md
25a. REC'D BY REGISTRAR: DATE APR 3 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04308

CERTIFICATE OF DEATH

04310

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garlock Memorial Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 714 George St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: IRENE — Last: KLINE

4. DATE OF DEATH: Month: March — Day: 30 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 1 1891

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Westminster Carroll Co Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jesse Fritz

14. MOTHER'S MAIDEN NAME: Valana McKane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: 220-16-3797

17. INFORMANT: Frisby S. Kline — Address: 714 George St Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Desease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

H200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychoses

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/18, 19 65 to 3/30, 19 67, that (I) (we) last saw the deceased alive on 3/30, 19 65, and that death occurred at 5:00 P.M. from causes and on the date stated above.

22a. SIGNATURE: J E Martin — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/31/67

22c. PHYSICIAN'S NAME (Type): Donald E. Martin, M.D.

22d. ADDRESS: 418 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 3 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04309

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04311

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARTINSBURG
d. STREET ADDRESS: U.S. VETERANS ADMINISTRATION HOSPITAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DAVID — Middle — Last LEIDMAN

4. DATE OF DEATH: Month MARCH — Day 16 — Year 19 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 29, 1923
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY: HOSPITAL MAINT.
11. BIRTHPLACE (State or foreign country): NEW YORK CITY
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ABRAHAM LEIDMAN
14. MOTHER'S MAIDEN NAME: JENNIE RESNICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: SCHWARTZ BROS., 114-03 QUEENS BLVD. Address: FOREST HILLS, NY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured Skull Fractured Femur Lft Hip
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): (Crushed Chest) Multiple Fractures of Ribs
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Head on collision with oncoming car
20c. TIME OF INJURY Month, Day, Year: Hour a.m. 3:15 p.m. 3-16 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): State Rt 11 C of
20f. (City or town) Williamsport (County) Washington (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): [illegible]
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 3/16/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/19/67
23c. NAME OF CEMETERY OR CREMATORY: MONTEFIORE
23d. LOCATION (City or Town) (County) (State): SPRINGFIELD, LONG ISLAND, NY

24. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REIST., RD.

25a. REC'D BY REGISTRAR DATE: MAR 21 1967
25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04310

CERTIFICATE OF DEATH

04312

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 402 Liberty St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Fred — Middle Lee — Last Lushbaugh
4. DATE OF DEATH: Month March — Day 8 — Year 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-26-14
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): salesman
10b. KIND OF BUSINESS OR INDUSTRY: beauty supply
11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Fred Lushbaugh
14. MOTHER'S MAIDEN NAME: Maude Boward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-09-7998
17. INFORMANT: June Lushbaugh — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
IMMEDIATE CAUSE (a): Pulmonary embolism with infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.
DUE TO (b): Chronic endocarditis with congestive — Indefinite
DUE TO: failure
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURREO While at work ☐ Nat While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 1966, to March 8, 1967 that (I) (we) last saw the deceased alive on March 8 1967, and that death occurred at 4:55 P.M. from causes and on the date stated above.

22a. SIGNATURE: B. B. Kneisley
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/10/67
22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.
22d. ADDRESS: 148 West Washington St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3-11-67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR: Minnich Funeral Home — ADDRESS: Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE: MAR 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04311 — 04313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 25 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Hagerstown 21701
   d. STREET ADDRESS: 122 S. Mulberry St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Virginia — Middle: Catherine — Lost: Martin

4. **DATE OF DEATH**: Month: March — Doy: 25 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 5, 1917

9. AGE (In yeors lost birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert E. Ruby

14. MOTHER'S MAIDEN NAME: Grace A. Goetz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 214-09-0303

17. **INFORMANT**: C. Edgar Martin — Address: 122 S. Mulberry St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (o): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
   DUE TO (b): Adeno-Carcinoma of Breast — 2 yrs
   Conditions, if any, which gave rise to immediate couse (o), stoting the underlying couse lost. DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Uremia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 19 [illegible] to March 25, 1967, that (I) (we) last saw the deceased alive on March 24 1967, and that death occurred at 11:55 AM, from causes and on the date stated above.

22a. SIGNATURE: M.E. Byrkit — ATTENDING M.D. PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-27-67

22c. PHYSICIAN'S NAME (Type): M.E. Byrkit

22d. ADDRESS: Williamsport Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/28/67

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City or Town) (County) (Stote): Hagerstown, Washington, Md.

24. FUNERAL DIRECTOR: Rest Haven Funeral Chapel — Wm. A. Hook

ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04312 04314

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Hagerstown
c. LENGTH OF STAY IN 1b: 8 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): Washington County Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Hagerstown 21-1
d. STREET ADDRESS: 351 Brookline Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREDERICK — Middle MERLE — Last MAYHUE

4. DATE OF DEATH: Month March — Day 6 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Oct 21 1905

9. AGE (In yeors last birthdoy): 61 yrs.

IF UNDER 1 YEAR: Months ___ Doys ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY: Fairchild Corp

11. BIRTHPLACE (County & Stote, or foreign country): Boonsboro Wash Co Md

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry W. Mayhue

14. MOTHER'S MAIDEN NAME: Amanda E. Hoover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service): ____

16. SOCIAL SECURITY NO.: 217-32-6181

17. INFORMANT — Address: James F. Mayhue Paradise Church Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) — Hagerstown Md. R # 6

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Bronchogenic Carcinoma
DUE TO
(b): ____
DUE TO
(c): ____

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, affice bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this haspital) attended the deceased from July 19, 1966, to March 6, 1967, that (I) (we) last saw the deceased alive on March 6 19 67, and that death occurred at 7:05 PM, from causes and on the date stated abave.

22o. SIGNATURE: A.M. Mandell M.D. — ATTENDING PHYS. ☑ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): A.M. Mandell M.D.

22d. ADDRESS: 119 E. Antietam St., Hagerstown, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/9/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Park

23d. LOCATION (City or Town) (County) (Stote): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md.

25o. REC'D BY REGISTRAR: MAR 10 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04313

CERTIFICATE OF DEATH

04315

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HANCOCK
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RURAL HANCOCK

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HANCOCK 21-1
d. STREET ADDRESS: RURAL HANCOCK
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

00

3. NAME OF DECEASED (Type or print): First ALBERT — Middle WALLACE — Last McCUSKER

4. DATE OF DEATH: Month MARCH — Day 8, — Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 1/17/1900
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON CO., MD.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN WILLIAM McCUSKER
14. MOTHER'S MAIDEN NAME: NANCY VIRGINIA BARNHART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: JOHN L. McCUSKER RD. #1, HANCOCK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: none
4201
DUE TO (b): Myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [✓]

2

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-20, 1967, to 2-21, 1967 that (I) (we) last saw the deceased alive on 2-21, 1967, and that death occurred at M, from causes and on the date stated above.

22a. SIGNATURE: Charles R Wierer — M.D. ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 3-9-67
22c. PHYSICIAN'S NAME (Type): Charles R. Wierer, M. D.
22d. ADDRESS: 238 E. Main St., Hancock, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/11/67
23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET PRESBYTERIAN
23d. LOCATION (City or Town) (County) (State): RURAL HANCOCK WASH. MD.

24. FUNERAL DIRECTOR — ADDRESS: Richard J. Snare Hancock, Md.
25a. REC'D BY REGISTRAR DATE: MAR 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04314 04317

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural - Boonsboro Md.
   c. LENGTH OF STAY IN 1b: 34 years
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Fahrney-Keedy Memorial Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown 21-1
   d. STREET ADDRESS: 16 North Mulberry Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ord — Middle: Beachley — Last: McFadyen

4. **DATE OF DEATH**: Month: 3 — Day: 15 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/2/1876

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & Sew Girl

10b. KIND OF BUSINESS OR INDUSTRY: Furniture

11. BIRTHPLACE (County & State, or foreign country): Washington, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ezra F. Beachley

14. MOTHER'S MAIDEN NAME: Caroline Main

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 213-16-0538

17. INFORMANT — Address: D.R. Beachley Sr. 227 N. Prospect St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis cardio vascular — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

4221

DUE TO (b): Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 4, 1967 to March 15, 1967 that (I) (we) last saw the deceased alive on March 15 1967, and that death occurred at 12 Noon from the causes and on the date stated above.

22a. SIGNATURE: G.W. LeVan — M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: March 15, 67

22c. PHYSICIAN'S NAME (Type): G. W. LeVan

22d. ADDRESS: Boonsboro, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/18/67

23c. NAME OF CEMETERY OR CREMATORY: Church Of Brethern Cemetery

23d. LOCATION (City, town or county) (State): Beaver Creek, Washington, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Wm. A. Nord — ADDRESS: Rest Haven Funeral Chapel Hagerstown, Md.

25a. REC'D BY REGISTRAR: MAR 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4) 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04315 — 04316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 WKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HANCOCK
d. STREET ADDRESS: W.MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARETTA — Middle RUTH — Last McKINLEY

4. DATE OF DEATH: Month 3 — Day 18 — Year 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5.26.1908

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): HANCOCK MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W WHORTON

14. MOTHER'S MAIDEN NAME: BEULAH BARNHART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): NO

16. SOCIAL SECURITY NO.: 220.26.0632

17. INFORMANT: A HART McKINLEY — Address: W.MAIN ST.HANCOCK MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 170X Carcinoma of Breast with Mets to bones
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from May, 1962 to 3-18, 1967, that (I) ~~(we)~~ last saw the deceased alive on 3-18 1967, and that death occurred at 4:35 P.M., from causes and on the date stated above.

22a. SIGNATURE: Dalton M. Welty — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/20/67

22c. PHYSICIAN'S NAME (Type): Dalton M. Welty, M.D.

22d. ADDRESS: 998 Potomac Ave., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3.21.67

23c. NAME OF CEMETERY OR ~~CREMATORY~~: MT.OLIVET

23d. LOCATION (City or Town) (County) (State): RURAL HANCOCK WASHINGTON MD.

24. FUNERAL DIRECTOR: Howard L Stone — ADDRESS: Hancock Md

25a. REC'D BY REGISTRAR DATE: MAR 27 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04316 04318

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: D. O. A
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital D. O.. A

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Williamsport 21-1
   d. STREET ADDRESS: Mt. Tammony
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Hershey — Last: Miller Jr.

4. DATE OF DEATH: Month: March — Day: 17 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 23 1922

9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months: 2 Days: 21 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Business Manager

10b. KIND OF BUSINESS OR INDUSTRY: Lumber Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Raymond H. Miller Sr.

14. MOTHER'S MAIDEN NAME: Edna Ankeney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes World War #2

16. SOCIAL SECURITY NO.: 220 16 0307

17. INFORMANT: Mrs. Marion Miller — Address: Mt. Tammony Williamsport, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Fracture Cervical Vertebra

DUE TO

(c) Compound Fracture Right Elbow

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Car struck bridge abutment.

20c. TIME OF INJURY Hour: 8:35 p.m. Month, Day, Year: 3-17- 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): U. S. 81

20f. (City or town) Hagerstown, (County) Washington, (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-18-67

Address (Street, city, town, or county): Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 20-67

22c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR — ADDRESS: Albert L. Leaf Williamsport, Md.

24a. REC'D BY REGISTRAR DATE: MAR 22 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judy

VR A15ME
5M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04317 04319

1. PLACE OF DEATH
a. COUNTY: Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 46 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1030 Main Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Daniel Middle: Ellsworth Last: Montgomery
4. DATE OF DEATH: Month: March Day: 28 Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 26 1902
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman Cabnet Shop
10b. KIND OF BUSINESS OR INDUSTRY: Organ Mfg.
11. BIRTHPLACE (County & State, or foreign country): Keedysville Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John F. Montgomery
14. MOTHER'S MAIDEN NAME: Nannie F. Wade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 213-01-2401
17. INFORMANT Address: Mrs. Grace Montgomery, Hagerstown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Endotoxic shock — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b): acute pyelonephritis — sev. days
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
6000

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic nephrosclerosis & pyelonephritis; arteriosclerotic C.V.D.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December, 1960, to March, 1967, that (I) (we) last saw the deceased alive on March 28, 1967, and that death occurred at 5 A M, from causes and on the date stated above.

22a. SIGNATURE: H. N. Weeks M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/28/67
22c. PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D.
22d. ADDRESS: 580 Northern Avenue Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-31-1967
23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
23d. LOCATION (City or Town) (County) (State): Smithsburg, Maryland

24. FUNERAL DIRECTOR: Munnich Funeral Home ADDRESS: Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE: APR 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yeager

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04318

CERTIFICATE OF DEATH

04320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 2 Weeks
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Hagerstown
   d. STREET ADDRESS: 1 West Wilson Blvd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First NANNIE — Middle PEARL — Lost MOSER-LUSHBAUGH

4. **DATE OF DEATH**: Month March — Doy 27 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feby 15 1885

9. AGE (In yeors last birthdoy) 82 yrs. — IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & Stote, or foreign country): Church Hill Fred Co Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Soule J. Warrenfeltz

14. MOTHER'S MAIDEN NAME: Clara Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service): ---

16. SOCIAL SECURITY NO.: 220-46-6139

17. **INFORMANT** Address: Lester Lushbaugh 1 West Wilson Blvd

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary occlusion — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
(b): athrosclerotic heart disease — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from January, 1958, to March, 1967, that (I) (we) last saw the deceased alive an March 26 1967, and that death occurred at ____ M, from causes and on the dote stoted above.

22o. SIGNATURE: Howard N. Weeks M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/28/67

22c. PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D.

22d. ADDRESS: 580 Northern Avenue Hagerstown, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/30/67

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City or Town) (County) (Stote): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR: Andrew K. Corfman — ADDRESS: Hagerstown Md. Funeral Home Inc

25o. REC'D BY REGISTRAR DATE: MAR 30 1967

25b. REGISTRAR'S SIGNATURE: Charles Jorge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04319

CERTIFICATE OF DEATH

04321

1. PLACE OF DEATH
a. COUNTY: WASHINGTON
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 HRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HANCOCK
21.1
d. STREET ADDRESS: RURAL 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First CHARLES Middle SIMMONS Last MUNSON

4. DATE OF DEATH: Month 3 Doy 19 Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: JULY 8 1880

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): HANCOCK MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W MUNSON

14. MOTHER'S MAIDEN NAME: PLESANT SOMMONS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: NORMAN R MUNSON RURAL 1 HANCOCK MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO
(b): pulmonary embolism — 8 hours
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
465X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): urinary tract infection severe

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from 9-25, 1966 to 3-19, 1967 that (I) (we) last saw the deceased alive an 3-19 1967, and that death accurred at 6 P M, fram causes and an the date stated abave.

22a. SIGNATURE: Joseph C Crisp MD — M.D. ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): JOSEPH C. CRISP

22d. ADDRESS: 580 northern ave Hagerstown

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3.23.67

23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET

23d. LOCATION (City or Town) (County) (State): RURAL 1 HANCOCK WASHINGTO MD.

24. FUNERAL DIRECTOR: Howard E Hose
ADDRESS: Hancock Md

25a. REC'D BY REGISTRAR DATE: MAR 27 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04320 04322

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural 1, Clear Spring
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural 1.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural 1
d. STREET ADDRESS: Clear Spring, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ralph; Middle: Franklin; Last: Myers

4. DATE OF DEATH: Month: March; Day: 12; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/23/21

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Myers

14. MOTHER'S MAIDEN NAME: Mazie Shank

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): W W 2

16. SOCIAL SECURITY NO.: 215-26-1849

17. INFORMANT: Mrs Genevieve Myers, Route 1, Clspg, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Penetrating gunshot wound of — INTERVAL BETWEEN ONSET AND DEATH: 1-10 Min
DUE TO (b): chest
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted gunshot of chest

20c. TIME OF INJURY: Hour: Approx 6 p.m.; Month, Day, Year: 3-12-1967

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Clear Spring (County): Wash. (State): Md

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward W. Ditto III, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Edward W. Ditto III

Address (Street, city, town, or county):

DATE SIGNED: 3-14-67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/15/67

22c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Memmorial Park

22d. LOCATION (City, town, or county): Hagerstown, (State): Md.

23. FUNERAL DIRECTOR: Margaret Rowland. ADDRESS: Clear Spring, Md.

24a. REC'D BY REGISTRAR DATE: MAR 16 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR AISME 5M 1/63

Items 18&21 Film 387 4-17-68

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04321 04323

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1½ years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown rural 21-1
d. STREET ADDRESS: RFD 6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle FRANK Last PENNINGTON
4. DATE OF DEATH: Month March Day 8, Year 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-24-1912
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): plastics dept.
10b. KIND OF BUSINESS OR INDUSTRY: aircraft mfg.
11. BIRTHPLACE (State or foreign country): Jefferson Co., W.Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frank B. Pennington
14. MOTHER'S MAIDEN NAME: Emma V. Collis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no
16. SOCIAL SECURITY NO.: 232-28-2688
17. INFORMANT Address: Mrs. Kathryn Pennington, Hag.,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured berry aneurysm of left middle cerebral artery
DUE TO (b): intracerebral hemorrhage of temporal lobe and insula on left side
DUE TO (c): Massive subarachnoid hemorrhage 2ndary hemorrhage into midbrain
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
330 X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary atherosclerosis with old myocardial infarction. Cardiac hypertrophy
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in driveway at home - Struck Head
20c. TIME OF INJURY Month, Day, Year: Hour 4 a.m. p.m. 3-6-1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Morgansville Wash Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Edward W. Ditto III, M.D.
EXAMINER'S NAME (Type): DR. EDWARD E. DITTO, III
Address (Street, city, town, or county): 217 W. WASHINGTON ST. HAG., MD.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 3-8-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-11-67
23c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
23d. LOCATION (City or Town) (County) (State): Shepherdstown, W.Va.

24. FUNERAL DIRECTOR: Minnich Funeral Home, Hagerstown, Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE: MAR 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04322 — 04324

M

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 21 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — 21-1
d. STREET ADDRESS: 132 Dogwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

79

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Agnes — Last: Pittinger

4. DATE OF DEATH: Month: March — Day: 14 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 8, 1884

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Tarrytown, N.Y.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Dennis Bannon

14. MOTHER'S MAIDEN NAME: Catherine O'Connor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 074-22-5795

17. INFORMANT: Mrs. Margaret Reif — Address: 132 Dogwood Drive, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral thrombosis	Unk
DUE TO (b)	Cerebral arteriosclerosis	Unk
DUE TO (c)	Generalized Arteriosclerosis	Unk

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile senile dementia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 2, 19 67, to March 14, 19 67, that (I) (we) last saw the deceased alive on March 14 19 67, and that death occurred at 3:40 M, from causes and on the date stated above.

22a. SIGNATURE: L L Packer Jr M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/14/67

22c. PHYSICIAN'S NAME (Type): L. L Packer Jr MD

22d. ADDRESS: Hagerstown, Md

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/16/67

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown, Washington, Md.

24. FUNERAL DIRECTOR: Wm. A. Hoot — **ADDRESS**: Rest Haven Funeral Chapel, Hagerstown, Md.

25a. REC'D BY REGISTRAR (DATE): MAR 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04323 Item #9 Film #0387 4/6/67 pc 04325

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d. STREET ADDRESS: 114 W. Salisbury Street
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

3. NAME OF DECEASED (Type or print): First: Alice Middle: Hoffman Last: Poole

4. DATE OF DEATH: Month: March Day: 31 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: April 10 1911

9. AGE (In years last birthday): 55 56 yrs. IF UNDER 1 YEAR: Months: 11 Days: 20 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Charles G. Poole

14. MOTHER'S MAIDEN NAME: Sadie Elizabeth Crowell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): ———

16. SOCIAL SECURITY NO.: 220 18 1047

17. INFORMANT: Mr. David K. Poole Jr. Address: 138 W Washington St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypercalemia incidental to — INTERVAL BETWEEN ONSET AND DEATH: 3-6 days

6000

DUE TO (b): anemia due chronic

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): pyelonephritis — 5-10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward W Ditto III M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4-1-67

EXAMINER'S NAME (Type): Edward W. Ditto III Hagerstown, Maryland.
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 3-67

22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR ADDRESS: Albert L. Leaf Williamsport Maryland

24a. REC'D BY REGISTRAR: APR 4 1967

24b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04324

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 45 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 909 Forest Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Percy — Middle: Joseph — Last: Potter

4. DATE OF DEATH: Month: March — Day: 4 — Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-17-1879

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): vice president

10b. KIND OF BUSINESS OR INDUSTRY: sand blast mfg.

11. BIRTHPLACE (County & State, or foreign country): Stratford on Avon Eng.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick K. Potter

14. MOTHER'S MAIDEN NAME: Susan A. Rutter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-6087

17. INFORMANT: Mary Potter — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism with infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO (b): Thrombosis right iliac vein — Indefinite
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
4660

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease with auricular fibrillation and heart block

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 21, 1967, to March 4, 1967 that (I) (we) last saw the deceased alive an March 3 1967, and that death occurred at 5:15 A. M, from causes and an the date stated above.

22a. SIGNATURE: B. B. Kneisley
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/6/67
22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.
22d. ADDRESS: 148 West Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3-6-67
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR — ADDRESS: Minnich Funeral Home Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE: MAR 9 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04325

CERTIFICATE OF DEATH

04327

1. PLACE OF DEATH
a. COUNTY: Washington
Western Maryland State Hosp. MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Western Maryland State Hosp.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cal.
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Sunderland - Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John Middle: R Last: Reed

4. DATE OF DEATH: Month: 3 Doy: 27 Year: 1967

5. SEX: MAle
6. COLOR OR RACE: N
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-3-1900
9. AGE (In years last birthdoy): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dennis Reed
14. MOTHER'S MAIDEN NAME: Christine Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):
16. SOCIAL SECURITY NO.: 218-12-9241
17. INFORMANT: Lionia Reed Address: Friendship AA. Co.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Bilateral Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO (b): Cerebral Thrombosis — 4 years
DUE TO (c): Arteriosclerosis, General — Unknown
Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost. 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyelonephritis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this haspital) attended the deceased from 9-9, 1966, to 3-27, 1967, that (I) (we) last saw the deceased alive an 3-26 1967, and that death accurred at 5:30 AM, from causes and on the date stated abave

22o. SIGNATURE: Navarro Layzequilla M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 3-27-67
22c. PHYSICIAN'S NAME (Type): Nevardo Layzequilla.
22d. ADDRESS: 1500 Penna. Ave. Hagerstown, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 3-31-67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Ch. Cem.
23d. LOCATION (City or Town) (County) (Stote): Sunderland Cal. Md

24. FUNERAL DIRECTOR: Pinkney E. Sowell ADDRESS: Prince Frederick Md
25o. REC'D BY REGISTRAR DATE: APR 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04326

CERTIFICATE OF DEATH

04328

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Boonsboro
c. LENGTH OF STAY IN 1b: 2 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Reeder Nursing Home

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Hagerstown 21-1
d. STREET ADDRESS: 620 Chestnut St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Elizabeth — Lost: Reeder

4. DATE OF DEATH: Month: March — Doy: 14, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: March 29, 1870

9. AGE (In yeors lost birthday): 96 yrs.

IF UNDER 1 YEAR: Months: 11 — Doys: 15
IF UNDER 24 HRS.: Hours: — Min.:

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & Stote, or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Lewis Shank

14. MOTHER'S MAIDEN NAME: Ella Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No.

16. SOCIAL SECURITY NO.: 220-52-2108

17. INFORMANT Address: 726 Maryland Ave.: Mrs. Goldie Henninger, Hagerstown. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Arteriosclerotic cardio vascular disease
DUE TO
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
(b) DUE TO
(c)
4221
INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While ot work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 4, 1967, to March 14, 1967, that (I) (we) last saw the deceased alive on March 14 1967, and that death occurred at 1 P. M, from causes and on the date stated above.

22o. SIGNATURE: G W LeVan — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: March 15, 1967

22c. PHYSICIAN'S NAME (Type): G. W. LeVan

22d. ADDRESS: Boonsboro, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3- 17- 67

23c. NAME OF CEMETERY OR CREMATORY: Locust Grove Cemetery

23d. LOCATION (City or Town) (County) (State): Locust Grove, Md.

24. FUNERAL DIRECTOR — **ADDRESS**: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.

25a. RECD BY REGISTRAR DATE: MAR 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04327

CERTIFICATE OF DEATH

04329

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 13 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 231 South Locust St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle WILLIAM Last REMSBURG Sr
4. DATE OF DEATH: Month March Day 28 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 27 1886
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Near Chewsville Wash Co Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph H. Remsburg
14. MOTHER'S MAIDEN NAME: Sarah E. Young
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ----
16. SOCIAL SECURITY NO.: 219-14-9819
17. INFORMANT: Clayton I. Remsburg Address: 204 Crestview Court Frederick Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): advanced atherosclerosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): dehydration - cachexia
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.: 3/28 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital
20f. (City or town) Hagerstown (County) Wash. (State) Md.

21. I certify that (I) (this hospital) attended the deceased from 3/28, 1967, to —, 19—, that (I) (we) last saw the deceased alive on 3/28 1967, and that death occurred at 4 P M, from causes and on the date stated above.

22a. SIGNATURE: A. M. Mandell M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/30/67
22c. PHYSICIAN'S NAME (Type): A. M. MANDELL, M.D.
22d. ADDRESS: 119 E. Antietam St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/31/67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) Hagerstown (County) Wash Co (State) Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc ADDRESS: Hagerstown Md.
25a. REC'D BY REGISTRAR DATE: APR 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jorge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04328 04330

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washingtonn County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Williamsport Md. RFD #1 21-1
d. STREET ADDRESS: Downsville Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Edith	May	Renner	March	17	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Oct. 4 1910	56 yrs.	5	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Rickard	Rose Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	------	None	Mr. Willis Renner	Downsville Pike Williamsport Md. RFD 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus & Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — **19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-6-60, 19__, to 3-17-, 1967, that (I) (we) last saw the deceased alive on 3-16, 1967, and that death occurred at 1:05 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E. R. Lardizabal M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3-17-67

22c. PHYSICIAN'S NAME (Type): E. R. LARDIZABAL, M. D. — 22d. ADDRESS: 300 NORTH POTOMAC ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burila	March 19-67	Greenlawn Cemetery	Williamsport Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Albert L. Leaf Williamsport, Md.	MAR 21 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04329

CERTIFICATE OF DEATH

04331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: WASHINGTON	**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): HAGERSTOWN — c. LENGTH OF STAY IN 1b: 43 YEARS	c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): HAGERSTOWN 21-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL	d. STREET ADDRESS: 136 N.POTOMAC STREET — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
NORMA	NMI	RIGGIN	MARCH	30	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	OCT. 9 1894	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
REGISTERED NURSE	MEDICINE	FLINT HILL VIRGINIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
EDWIN RAMEY	ALBENIA PAYNE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
NO	216-46-8891	WILLIAM C RIGGIN	136 N.POTOMAC ST. HAGERSTOWN MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cachexia & uremia	1 mo
DUE TO (b)	Generalized metastasis	6 mos
DUE TO (c)	Adenocarcinoma of stomach	2 yrs

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
	none

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m.	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
none 19		none	-	-	-

21. **I certify** that (I) (~~the hospital~~) attended the deceased from Sept, 19 61, to Mar 30, 19 67, that (I) (we) last saw the deceased alive an Mar 30 19 67, and that death occurred at 3 AM M, from causes and an the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
H.R. Tritch Jr MD		3/31/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
H.R.TRITCH JR. M. D.	302 N.POTOMAC ST.HAGERSTOWN MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	4/1/67	REST HAVEN CEMETERY	HAGERSTOWN WASHINGTON MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
CHARLES M ROUZER HAGERSTOWN MARYLAND	APR 5 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04330

CERTIFICATE OF DEATH

04332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21-1
d. STREET ADDRESS: oller Apts
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle ALBERTA Last RITCHIE

4. DATE OF DEATH: Month March Day 3 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov 7 1870

9. AGE (In years last birthday): 96 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Va.. Purcellville Loudon Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Alder

14. MOTHER'S MAIDEN NAME: Hannah Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service): -----

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Mary Helen James Address: Moller Apts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — Hagerstownb Md.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c): ___
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
4200
INTERVAL BETWEEN ONSET AND DEATH: ? Several weeks
Unknown.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obstructive jaundice - cause unknown -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-3, 1967, to 3-3, 1967, that (I) (we) last saw the deceased alive on 3-3 1967, and that death occurred at 11 P. M, from causes and on the date stated above.

22a. SIGNATURE: John H Hornbaker M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-4-67

22c. PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D.

22d. ADDRESS: 154 W. Washington St., Hagerstown, Md. 21740

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/6/67

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 8 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04331 — 04333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon popers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 20 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ~~WASHINGTON~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CLEARSPRING 21-1
d. STREET ADDRESS: RT.#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD — Middle VIRL — Last ROBINSON

4. DATE OF DEATH: Month MARCH — Day 2 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/19/1913

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECRICIAN

10b. KIND OF BUSINESS OR INDUSTRY: MACHINE EQUIP. CORP.

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAVID FILMORE ROBINSON

14. MOTHER'S MAIDEN NAME: MARY FAITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-16-0139

17. INFORMANT: MRS. EDNA M. ROBINSON — Address: CLEARSPRING RT.#1 MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
490X
IMMEDIATE CAUSE (a): ~~XXXX~~ Terminal bilateral lobular pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Chronic hepatic cirrhosis Laennec type with ascites — Known 2 months
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1966, to March 2, 1967 that (I) (we) last saw the deceased alive an March 1 1967, and that death occurred at 3:30 A. M, from causes and on the date stated above.

22a. SIGNATURE: B. B. Kneisley

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/3/67

22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.

22d. ADDRESS: 148 West Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3/4/67

23c. NAME OF CEMETERY OR CREMATORY: MT. VIEW CEM.

23d. LOCATION (City or Town) (County) (State): RINGOLD WASH. MD.

24. FUNERAL DIRECTOR: W. T. Norment — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, ond in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04332

CERTIFICATE OF DEATH

04334

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 47 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): 15 CYPRESS STREET

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): HAGERSTOWN 21-1
d. STREET ADDRESS: 15 CYPRESS STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JOHNNIE — Middle McCULLEN — Last ROE

4. **DATE OF DEATH**: Month MARCH — Day 5 — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 24, 1894

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Haurs — Min.

10a. USUAL OCCUPATION (Give kind of wark done during most of working life, even if retired): RETIRED CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: DOOR MFG.

11. BIRTHPLACE (County & State, or foreign country): TALBOT CO., MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES A. ROE

14. MOTHER'S MAIDEN NAME: CLARA STUPES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dates of service): ----------

16. SOCIAL SECURITY NO.: 214-09-5886

17. **INFORMANT**: MRS. RUTH ROE — Address: 15 CYPRESS STREET HAGERSTOWN, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
Conditians, if any, which gave rise to immediate cause (a). stating the underlying cause last.
(b): Extensive coronary artery disease — years
DUE TO
(c): Generalized arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov. 19 65, to 5 March 19 67, that (I) (we) last saw the deceased alive on 24 Feby 19 67, and that death accurred at 19 P M, from causes and an the date stated above.

22a. SIGNATURE: John C. Stauffer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/7/1967

22c. PHYSICIAN'S NAME (Type): JOHN C. STAUFFER M.D.

22d. ADDRESS: 145 S. PROSPECT ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MARCH 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City or Town) (County) (State): HAGERSTOWN, MARYLAND

24. FUNERAL DIRECTOR: CHARLES M. ROUZER — ADDRESS: HAGERSTOWN, MARYLAND

25a. RECD BY REGISTRAR DATE: MAR 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04333 **CERTIFICATE OF DEATH** 04333

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 1 month-3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 22 Elizabeth Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosie — Middle: May — Last: Romesburg

4. DATE OF DEATH: Month: March — Day: 3 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 18, 1892

9. AGE (in years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House duties

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Pleasant Valley, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wesley Marshall

14. MOTHER'S MAIDEN NAME: Mary Belle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Melvin E. Ashton-Martinsburg, West Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic failure — INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO (b): Cirrhosis of uncertain cause — unknown
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5810

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January, 1967, to March, 1967, that (I) (we) last saw the deceased alive on March 1 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Carl Spencer — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-5-1967

23c. NAME OF CEMETERY OR CREMATORY: Rosedale Cemetery

23d. LOCATION (City, town or county) (State): Martinsburg, Berkeley, W.Va.

24. FUNERAL DIRECTOR: Howard K. Brown Funeral Home — ADDRESS: Martinsburg, W.Va.

25a. REC'D BY REGISTRAR DATE: MAR 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04334 04336

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Maryland State Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21-1
d. STREET ADDRESS: 418 Fremont St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Lucretia — Middle: — Last: Ross

4. DATE OF DEATH: Month: March — Day: 1 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1917

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Pa. Myersdale Somerset Co

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Calvin Holiday

14. MOTHER'S MAIDEN NAME: Clara C. Hatton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dates of service): ----

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Lester W. Ross 418 Fremont St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): carcinoma of cervix — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~(I) (this hospital)~~ attended the deceased from 1-16-67, 1967, to 3-1, 1967, that (I) ~~(we)~~ last saw the deceased alive on 2-28 1967, and that death occurred at 1A M, from causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: March 1, 1967

22c. PHYSICIAN'S NAME (Type): VICTOR L. RAMOS, MD.

22d. ADDRESS: Western Md. State Hospital Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/4/67

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Mdo

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md

25a. REC'D BY REGISTRAR — DATE: MAR 3 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04335 04337

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Washington Co. — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Rural-Hagerstown Md.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Penna. — b. COUNTY: Franklin
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Chambersburg 17201 75-3
   d. STREET ADDRESS: 236 Lincoln Way East
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dr. Lewis — Middle: H. — Last: Seaton

4. DATE OF DEATH: Month: March — Day: 21st. — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 30th. 1885

9. AGE (In years last birthday): 81 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10b. KIND OF BUSINESS OR INDUSTRY: Dr.

11. BIRTHPLACE (County & State, or foreign country): Uniontown Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis M. Seaton

14. MOTHER'S MAIDEN NAME: Julia Stacy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1st W.War

16. SOCIAL SECURITY NO.: 179-36-3418

17. INFORMANT (Address): 17500 McDade Court
    Dr. Lewis H. Seaton 2nd. Derwood Md. -20855

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Coronery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
    DUE TO
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    (b): Hypertensive cardiovasc. Disease — 2 yrs.
    DUE TO
    (c): Arteriosclerosis - Generalized — 2 yrs. +

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral vasc. Arteriosclerotic Disease - Senility

    19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 2, 1966, to Mar. 21, 1967, that (I) (~~we~~) last saw the deceased alive on March 21 1967, and that death occurred at 5:30 P.M., from causes ond on the date stoted above.

22a. SIGNATURE: Lloyd A. Hoffman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Lloyd A. HoFFman

22d. ADDRESS: 214 N. Pot. St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/23/1967

23c. NAME OF CEMETERY OR CREMATORY: Lincoln Cemetery

23d. LOCATION (City or Town) (County) (Stote): Chambersburg - Franklin-Pa.

24. FUNERAL DIRECTOR — ADDRESS: Sellers Funeral Home Chambersburg Penna.

25a. REC'D BY REGISTRAR — DATE: MAR 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

17201

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04336 — 04338

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 Hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R#6
d. STREET ADDRESS: Salem Church Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First SAMUEL — Middle CALVIN — Last SECRIST

4. DATE OF DEATH: Month March — Day 8 — Year 1967

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	July 28 1880	86 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Sylvan Franklin Co Pa.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Abraham Secrist
14. MOTHER'S MAIDEN NAME: Susan Zimmerman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ---
16. SOCIAL SECURITY NO.: None
17. INFORMANT: David P. Secrist — Address: Hagerstown Md R #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs.
DUE TO (b): Arteriosclerotic heart Disease — not known
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Gastro-Intestinal Bleeding — Cause not known
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-7, 1967 to 3-8, 1967, that (I) (we) last saw the deceased alive on 3-7 1967, and that death occurred at 7:44 A.M. from causes and on the date stated above.

22a. SIGNATURE: Arturo Riggo M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 3/8/67
22c. PHYSICIAN'S NAME (Type): ARTURO RIGGO
22d. ADDRESS: 159 W. Washington St.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3/11/67	Lutheren Cemetery	Sylvan Franklin Co Pa

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — **ADDRESS**: Hagerstown Md.
25a. REC'D BY REGISTRAR DATE: MAR 10 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04337

04339

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: WASHINGTON — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILLIAMSPORT c. LENGTH OF STAY IN 1b: 45 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILLIAMSPORT 21-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): HOME	d. STREET ADDRESS: 23 W. CHURCH ST. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
HARRY	HORINE	SHANK	3	28	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		3.2.1895	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SUPERINTENDANT TEXTILE	MILLS	FREDERICK COUNTY MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE SHANK	ESTA HORINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		ANNIE A SHANK 23 W. CHURCH WILLIAMSPORT MD. T

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction	4 hrs
DUE TO (b)	Atherosclerosis	10 yrs
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): No

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			Williamsport Maryland

21. **I certify** that (I) (this hospital) attended the deceased from November 25 1960, to Feb. 9, 1967, that (I) (we) last saw the deceased alive on Feb. 9 1967, and that death occurred at 5:30 M, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
M. E. Byrkit		March 30, 1967 Maryland
22c. PHYSICIAN'S NAME (Type) M. E. Byrkit		22d. ADDRESS 28 West Potomac Street, Williamsport

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	3.31.67	ST. PAUL	RURAL CLEARSPRING WASH. MD

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Howard F. Hose Williamsport md	APR 3 1967	[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04338

CERTIFICATE OF DEATH

04340

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 MOS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): D.O.A. WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN 21-1
d. STREET ADDRESS: LEITERSBURG PIKE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALBERT — Middle: BERLEY — Last: SHEALY

4. DATE OF DEATH: Month: MARCH — Day: 7 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 20, 1900

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SCHOOL TEACHER

10b. KIND OF BUSINESS OR INDUSTRY: PUBLIC SCHOOL

11. BIRTHPLACE (County & State, or foreign country): NEWBERRY CO.,S.CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NOAH E. SHEALY

14. MOTHER'S MAIDEN NAME: JANE CHAPMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 456-03-5034

17. INFORMANT: MRS. KATHERINE SHEALY — Address: HAGERSTOWN, MARYLAND LEITERSBURG PIKE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: Sec
DUE TO (b): Arteriosclerotic Heart Disease — 5 yrs
DUE TO (c): Arteriosclerotic Heart Disease — Unk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 3, 1967, to March 7, 1967, that (I) (we) last saw the deceased alive on March 7 1967, and that death occurred at 12:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Lawrence L Packer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/7/1967

22c. PHYSICIAN'S NAME (Type): LAWRENCE L. PACKER, JR. M.D.

22d. ADDRESS: 145 W. WASHINGTON ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE THEREOF: 3/7/1967

23c. NAME OF CEMETERY OR CREMATORY: GRAND VIEW MEM.PARK CEM.

23d. LOCATION (City or Town) (County) (State): ROCK HILL S. CAROLINA

24. FUNERAL DIRECTOR: CHARLES M. ROUZER — ADDRESS: HAGERSTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: MAR 10 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04339 04341

1. PLACE OF DEATH
a. COUNTY: Washington MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Rural Keedysville
c. LENGTH OF STAY IN 1b: 26 Years
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address): Rfd. 1

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn): Rural Keedysville 21-1
d. STREET ADDRESS: Rfd. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Blanche Middle Estelle Last Shelby
4. DATE OF DEATH: Month March Day 5, Year 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: March 14, 1900
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months 11 Days 21
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind af wark dane during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (Caunty & State, ar foreign country): Frederick Co., Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Haller
14. MOTHER'S MAIDEN NAME: Lola Younkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknawn) (If yes give war ar dates af service): No.
16. SOCIAL SECURITY NO.: 216-48-6566
17. INFORMANT Address: Mrs. Virginia Hutzell, Rfd. 2, Boonsboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio Vascular Disease
4221
DUE TO
Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II af item 18.)
20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19
20d. INJURY OCCURRED While at wark ☐ Nat While at wark ☐
20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)
20f. (City ar tawn) (Caunty) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1, 1967 to March 5, 1967, thot (I) (we) last saw the deceased alive on March 4 1967, and that death occurred at 1 P.M., from causes and on the date stated above.

22a. SIGNATURE: G. W. LeVan M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 7, 1967
22c. PHYSICIAN'S NAME (Type): G. W. LeVan
22d. ADDRESS: Boonsboro Washington

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-8-67
23c. NAME OF CEMETERY OR CREMATORY: Reformed Cemetery
23d. LOCATION (City ar Tawn) (Caunty) (State): Middletown, Md.

24. FUNERAL DIRECTOR ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.
25a. REC'D BY REGISTRAR DATE: MAR 9 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. af Health priar to burial, cremation, or removal, and in any event, within 72 haurs after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04447

04340

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Coffman Home for Aging

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
d. STREET ADDRESS: Springfield State Hosp.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELSIE Middle MAY Last SHIPP

4. DATE OF DEATH: Month March Day 18 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 6 1895

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (County & State, or foreign country): Mercersburg Franklin Co Pa.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Cyrus J. Shipp

14. MOTHER'S MAIDEN NAME: Mary Blair

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: 215-14-1904

17. INFORMANT: Mrs Marie Heyworth
Address: 66 West Side Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO
(b): Atherosclerotic heart disease — Unknown
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 18, 19 67 to Mar. 18, 19 67, that (I) (we) last saw the deceased alive on No previous attendance 19 ___, and that death occurred at 11:55 M, from causes and on the date stated above.

22a. SIGNATURE: William T. Layman M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Mar 21, 1967

22c. PHYSICIAN'S NAME (Type): William T. Layman, M.D.

22d. ADDRESS: 100 Professional Arts Bldg, Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/22/67

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown Washington Co Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc
ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR: MAR 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04341 04342

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD 1, Clear Spring 21-1
d. STREET ADDRESS: RFD 1, Clear Spring
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Allen Last: Shirley
4. DATE OF DEATH: Month: March Day: 5th Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 13, 67
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR Months: Days: 21 IF UNDER 24 HRS. Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Wash. Co. Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edwin T. Shirley
14. MOTHER'S MAIDEN NAME: Mary Ellen Hull
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Edwin T. Shirley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congenital Heart desease
7545
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Bronchopneumonia
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 2 days / 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Moving-myelocete Clubbands & feet
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2/13/, 1967, to 3/5/, 1967, that (I) (~~we~~) last saw the deceased alive on 3/4/ 1967, and that death occurred at 5:25 M, from the causes and on the date stated above.

22a. SIGNATURE: J. M. Bacon Jr. M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/6/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 7, 67
23c. NAME OF CEMETERY OR CREMATORY: Park Head
23d. LOCATION (City, town or county) (State): Wash. Co. Maryland
24. FUNERAL DIRECTOR ADDRESS: Donald E. Thompson Clear Spring,
25a. REC'D BY REGISTRAR DATE: MAR 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

7-227107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04342 04343

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILLIAMSPORT
c. LENGTH OF STAY IN 1b: 3 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOMEWOOD CHURCH HOME, INC.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN 21-1
d. STREET ADDRESS: 309 S. MULBERRY ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle MAY Last SIGLER

4. DATE OF DEATH: Month MARCH Day 21 Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 10/28/1870

9. AGE (In years last birthday): 96 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ISAAC REYNOLDS

14. MOTHER'S MAIDEN NAME: ANN REBECCA FULTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 220-52-2109

17. INFORMANT: J1 MR. VERNON R. SNIDER Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Several years
DUE TO
(b): Senility
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-2- , 19 64, to 3-21- , 19 67 that (I) (we) last saw the deceased alive on 2-27- , 19 67, and that death occurred at 7 1.3 M, from causes and on the date stated above.

22a. SIGNATURE: Dr. E. W. Ditto, Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3- 22-67

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.

22d. ADDRESS: 215 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3/23/67

23c. NAME OF CEMETERY OR CREMATORY: CAVETOWN REFOMED CHURCH

23d. LOCATION (City or Town) (County) (State): CAVETOWN WASH. MD.

24. FUNERAL DIRECTOR: W. T. Mermit — **ADDRESS**: Hagerstown, Md.

25a. REC'D BY REGISTRAR (Date): MAR 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04344

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 15 Young Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro
d. STREET ADDRESS: 15 Young Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Guy — Middle: Wilbur — Last: Smith

4. DATE OF DEATH: Month: March — Day: 17, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 22, 1900

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months: 2 — Days: 25
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY: Aircraft

11. BIRTHPLACE (State or foreign country): Boonsboro, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Donivan C. Smith

14. MOTHER'S MAIDEN NAME: Martha E. Lapole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 220-05-6807

17. INFORMANT: Address: Hagerstown, Md. — Mrs. Myrtle E. Smith, 15 Young Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Few minutes
DUE TO
(b): Arteriosclerotic Vascular Disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 3-18-67

Address (Street, city, town, or county): Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3- 20- 67

23c. NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery

23d. LOCATION (City or Town) (County) (State): Boonsboro, Md.

24. FUNERAL DIRECTOR — ADDRESS: John H. East, Jr. 112 N. Main St. Boonsboro, Md.

25a. REC'D BY REGISTRAR DATE: MAR 21 1967

25b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04344

CERTIFICATE OF DEATH

04345

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Chewsville P.O. Box 92
c. LENGTH OF STAY IN 1b: 11 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Waltz Road

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Chewsville Box # 92
d. STREET ADDRESS: Waltz Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: VICTOR — Middle: (NMN) — Last: SMITH

4. **DATE OF DEATH**: Month: March — Day: 8 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Oct 10 1894

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Bank

11. BIRTHPLACE (County & State, or foreign country): Carnegie Alleganey Co Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph A. Smith

14. MOTHER'S MAIDEN NAME: Katherine Keuster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): -----

16. SOCIAL SECURITY NO.: 567-01-2796

17. **INFORMANT** Address: Mrs Corena Smith Chewsville Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastases, abdominal & generalized — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO (b): Sarcoma, primary in jejunum — 3 months
DUE TO (c): — certain
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 28, 1967, to Mar. 8, 1967, that (I) (we) last saw the deceased alive on Mar. 8 1967, and that death occurred at 6:15 P.M. from causes and on the date stated above.

22a. SIGNATURE: William T. Layman M.D. — ATTENDING PHYS. ☐ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): William T. Layman, M.D.

22d. ADDRESS: 100 Professional Arts Bldg, Hag., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/13/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Park

23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: MAR 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04345 Hypatia Snider

CERTIFICATE OF DEATH

04346

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pa. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro 75-3
d. STREET ADDRESS: 22 Mt. Airy Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print): First: Hypatia — Middle: Ann — Last: Snider

4. DATE OF DEATH: Month: March — Day: 6, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/6/1896

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Waynesboro Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles D. Snider

14. MOTHER'S MAIDEN NAME: Mamie Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Paul McFerren, Waynesboro Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO (b): Ventricular Fibrillation — 4 hours
DUE TO (c): Arteriosclerotic Heart Disease — 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 1967, to March 6, 1967, that (I) (we) last saw the deceased alive on March 6, 1967, and that death occurred at 2:40 PM, from causes and on the date stated above.

22a. SIGNATURE: Edson B Moody — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/6/67

22c. PHYSICIAN'S NAME (Type): Edson B. Moody

22d. ADDRESS: 145 S. Prospect St. Hagerstown, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/9/67

23c. NAME OF CEMETERY OR CREMATORY: Price

23d. LOCATION (City or Town) (County) (State): Waynesboro #2, Franklin Pa.

24. FUNERAL DIRECTOR: Walter Y. Hoover — ADDRESS: Waynesboro Pa.

25a. REC'D BY REGISTRAR DATE: MAR 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04346 04347

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 1yr 6days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Route #1 Sharpsburg 21-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Robert — Last Snyder

4. DATE OF DEATH: Month March — Day 24 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 24 1879

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months 8 — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner

10b. KIND OF BUSINESS OR INDUSTRY: City Park Hagerstown

11. BIRTHPLACE (County & State, or foreign country): Scrapple West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Snyder

14. MOTHER'S MAIDEN NAME: Katherine Elizabeth Mimnich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ------

16. SOCIAL SECURITY NO.: 215 20 8456 A

17. INFORMANT: Address: Mrs. Mary Hensell Rt #1 Sharpsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebral Atherosclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1966, to ____, 19__, that (I) (we) last saw the deceased alive on March 22 19 67, and that death occurred at 7 P. M, from the causes and on the date stated above.

22a. SIGNATURE: M. E. Byrkit M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-27-67

22c. PHYSICIAN'S NAME (Type): M. E. BYRKIT

22d. ADDRESS: 28 West Potomac Street Williamsport, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 28-67

23c. NAME OF CEMETERY OR CREMATORY: Reform Church Cemetery

23d. LOCATION (City, town or county) (State): Shepherdstown, W. Va.

24. FUNERAL DIRECTOR: Albert L. Leaf — ADDRESS: Williamsport, Md.

25a. REC'D BY REGISTRAR DATE: MAR 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04347

CERTIFICATE OF DEATH

04348

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1509 Virginia Ave.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21-1
d. STREET ADDRESS: 1509 Virginia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jacob — Middle: Alvey — Last: Snyder

4. **DATE OF DEATH**: Month: March — Day: 15, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 10, 1883

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: 7 — Days: 5
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sexton

10b. KIND OF BUSINESS OR INDUSTRY: Church

11. BIRTHPLACE (County & State, or foreign country): Mt. Carmel, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jacob Milton Snyder

14. MOTHER'S MAIDEN NAME: Ella Hildebrand

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 220-16-0812

17. **INFORMANT**: Mrs. Goldie D. Snyder, 1509 Virginia Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: Several days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Vascular Disease — 5 years
DUE TO
(c) Leukemia Lymphatic Chronic — 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 1, , 1963, to March 15, 1967, that (I) (we) last saw the deceased alive on March 13, 1967, and that death occurred at 5 A. M, from causes and on the date stated above.

22a. SIGNATURE: E. W. Ditto

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: March 17, 1967

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.

22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3- 18- 67

23c. NAME OF CEMETERY OR CREMATORY: SalemReformed Cemetery

23d. LOCATION (City or Town) (County) (State): Rural Hagerstown, Md.

24. FUNERAL DIRECTOR — ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.

25a. REC'D BY REGISTRAR DATE: MAR 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04348

CERTIFICATE OF DEATH

04349

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): HAGERSTOWN
d. STREET ADDRESS: 43 MEALEY PARKWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First BABY Middle GIRL Lost STEWART

4. DATE OF DEATH: Month 3 Doy 31 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-31-67
9. AGE (In yeors lost birthday) yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min. 7

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): WASHINGTON Co. MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: LAURENCE EVERETT STEWART
14. MOTHER'S MAIDEN NAME: PATRICIA ALICE MACARTHUR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MOTHER — Address: 43 MEALEY PKWY.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Atelectasis
DUE TO (b): Immaturity
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (o), stoting the underlying couse lost.
7625
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospitol) ottended the deceased from 3/31, 1967, to 3/31, 1967, that (I) (we) last saw the deceased alive an 3/31 1967, and that death accurred at 4:10 AM, fram causes and an the date stated above.

22a. SIGNATURE: F. D. Dove Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/3/67
22c. PHYSICIAN'S NAME (Type): F. D. DOVE, JR., M.D.
22d. ADDRESS: 214 N. POTOMAC ST., HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: APRIL 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: WASHINGTON COUNTY HOSPITAL
23d. LOCATION (City or Town) (County) (State): HAGERSTOWN WASH. MD.

24. FUNERAL DIRECTOR: John S. Groffen, adm. — ADDRESS: Wash. Co. Hosp.
T-227354
25a. REC'D BY REGISTRAR DATE: APR 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04349

CERTIFICATE OF DEATH

04350

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 144 So Mulberry St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CLARENCE — Middle WILLIAM — Last STOUFFER

4. **DATE OF DEATH**: Month March — Day 8 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 16 1883

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt of Mails U.S. Post Office

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Downsville Wash Co Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: W. Cornelius Stouffer

14. MOTHER'S MAIDEN NAME: Emma C. Hull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: 217-28-6873

17. **INFORMANT**: John R. Stouffer Sr Hagerstown
Address: 1800 Heisterboro Road

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Larynx — INTERVAL BETWEEN ONSET AND DEATH: 2 yr
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

161X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/2, 1963, to 3/8, 1967, that (I) (we) last saw the deceased alive on 3/3/67 19___, and that death occurred at 6:40 P M, from causes and on the date stated above.

22a. SIGNATURE: Robert V. Campbell M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/10/67

22c. PHYSICIAN'S NAME (Type): Robert V. Campbell

22d. ADDRESS: Hagerstown Md

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/12.67

23c. NAME OF CEMETERY OR CREMATORY: Lutheren Cemetery

23d. LOCATION (City or Town) (County) (State): Bakersville Wash Co Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md

25a. REC'D BY REGISTRAR DATE: MAR 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

BP

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04350

CERTIFICATE OF DEATH

04351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 47 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MARTIN MANOR CONV. HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 1004 MULBERRY AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE — Middle GASKILL — Last TOMLINSON

4. DATE OF DEATH: Month MARCH — Day 9 — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 2,1897

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MACHINIST

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (County & State, or foreign country): PHILADELPHIA CO., PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT S. TOMLINSON

14. MOTHER'S MAIDEN NAME: MARY NEALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dotes of service): ----------

16. SOCIAL SECURITY NO.: 705-10-4622

17. INFORMANT: MRS. LOUISE TOMLINSON 1004 MULBERRY AVE. HAGERSTOWN, MARYLAND (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b): Proteus — 4 days
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

1534

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Hypertensive and atherosclerotic heart disease.
Malignant tumor of prostate--paraganglioma?

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from December, 1965, to March 9, 1967, that (I) (~~we~~) last saw the deceased alive an March 9 1967, and that death accurred at 7:50 P.M., from causes and an the date stated abave.

22a. SIGNATURE: Wm. T. Layman, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: March 10, 1967

22c. PHYSICIAN'S NAME (Type): WILLIAM T. LAYMAN M.D.

22d. ADDRESS: PROFESSIONAL ARTS BG. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MARCH 13,1967

23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY

23d. LOCATION (City or Town) (County) (State): HAGERSTOWN, MARYLAND

24. FUNERAL DIRECTOR: CHARLES M. ROUZER — ADDRESS: HAGERSTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: MAR 15 1967

25b. REGISTRAR'S SIGNATURE: Florence Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04351

CERTIFICATE OF DEATH

04352

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonesboro
   c. LENGTH OF STAY IN 1b: 10 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Reeder Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21-1
   d. STREET ADDRESS: 231 Westside Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mary — Middle: Alverta — Last: Troup

4. **DATE OF DEATH**: Month: March — Day: 13 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 23, 1880

9. AGE (In years last birthday): 86 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Hanover, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Ernst

14. MOTHER'S MAIDEN NAME: Lidia Auchey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 175-10-5886

17. INFORMANT: Mr. Clair H. Troup 231 Westside Ave. — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Arteriosclerotic cardio vascular — INTERVAL BETWEEN ONSET AND DEATH: 10yr
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): disease
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 7, 1967, to March 14, 1967, that (I) (we) last saw the deceased alive on March 11 1967, and that death occurred at 11A M, from causes and on the date stated above.

22a. SIGNATURE: G. Wilevan — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-14-67

22c. PHYSICIAN'S NAME (Type): G. Wilevan

22d. ADDRESS: Boonsboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/16/67

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown, Washington, Md.

24. FUNERAL DIRECTOR: Wm. C. Hurst — ADDRESS: Rest Haven Funeral Chapel Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAR 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04352

CERTIFICATE OF DEATH

04353

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Keedysville
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 54 N. Main St.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Keedysville
   d. STREET ADDRESS: 54 N. Main St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Thomas — Middle: Ray — Last: Valentine

4. **DATE OF DEATH**: Month: March — Day: 3, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 16, 1905

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months: 2 — Days: 19
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Upholster

10b. KIND OF BUSINESS OR INDUSTRY: Furniture

11. BIRTHPLACE (County & State, or foreign country): Keedysville, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William A. Vatentine

14. MOTHER'S MAIDEN NAME: Martha Emerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 214-09-6677

17. **INFORMANT** Address: Mr. C. Foster Valentine, Keedysville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO (b): Arteriosclerotic Heart Disease — years
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-1-, 1965, to 3-3-, 1967, that (I) (we) last saw the deceased alive on 3-3- 1967, and that death occurred at 8P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-4-67

22c. PHYSICIAN'S NAME (Type): JOSEPH SECONDARI

22d. ADDRESS: BOONSBORO MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-6-67

23c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery

23d. LOCATION (City or Town) (County) (State): Keedysville, Md.

24. FUNERAL DIRECTOR ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.

25a. REC'D BY REGISTRAR DATE: MAR 7 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04353 04354

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Hagerstown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Washington County Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Hagerstown
d. STREET ADDRESS: 324 Vista St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DORIS — Middle MARIE — Lost VULGAMOTT

4. DATE OF DEATH: Month March — Doy 26 — Year 19 67

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Feb. 24, 1921
9. AGE (In yeors last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Derrick F. Byrd
14. MOTHER'S MAIDEN NAME: Agnes B. Ashby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Jack Osborne, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Renal Failure

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-23, 1967, to 3-27, 1967, that (I) (we) last saw the deceased alive on 3-27 1967, and that death occurred at 7:20 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-27-67
22c. PHYSICIAN'S NAME (Type): E. A. Landgrabe
22d. ADDRESS: 30 N. Potomac, Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3-29-67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR ADDRESS: Minnich Funeral Home, Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE: MAR 30 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04354

CERTIFICATE OF DEATH

04355

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pen Mar, Penna.
   c. LENGTH OF STAY IN 1b: 47 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pen Mar, Penna.
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Earl — Middle: Dean — Last: Werdebaugh

4. **DATE OF DEATH**: Month: March — Day: 27 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/23/1892

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Railway Express

11. BIRTHPLACE (County & State, or foreign country): Franklin, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry S. Werdebaugh

14. MOTHER'S MAIDEN NAME: Laura Greenwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 715-03-4676

17. **INFORMANT**: Mrs. Thelma Werdebaugh — Address: Box 44 Pen Mar, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis Cardio Vascular Renal — 5 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** thot (I) (this hospitol) attended the deceosed from March 27, 1967, to March 27, 1967, thot (I) (we) lost sow the deceosed olive on March 27, 1967, ond that death occurred at 11:45 M, from couses ond on the dote stated above.

22a. SIGNATURE: Robert A. Shaffer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 28 March 1967

22c. PHYSICIAN'S NAME (Type): Robert A. Shaffer, M.D.

22d. ADDRESS: Blue Ridge Summit, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/30/1967

23c. NAME OF CEMETERY OR CREMATORY: Burns Hill

23d. LOCATION (City or Town) (County) (State): Waynesboro, Franklin, Pa.

24. FUNERAL DIRECTOR: Walter Y. Grace — ADDRESS: Waynesboro, Penna.

25a. REC'D BY REGISTRAR DATE: MAR 30 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Yingst

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04355

CERTIFICATE OF DEATH

04356

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 Days

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Boonsboro 21-1
d. STREET ADDRESS: 115 N. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): Garlock Mem. Convalesent Hospital 90

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Louise — Lost: Wheeler

4. DATE OF DEATH: Month: March — Doy: 2, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 26, 1882

9. AGE (In yeors last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: 1 — Days: 6
IF UNDER 24 HRS.: Hours — Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Boonsboro, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William Wheeler

14. MOTHER'S MAIDEN NAME: Laurette Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No.

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mrs. Charles L. Meredith, Boonsboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of maxillary bone — INTERVAL BETWEEN ONSET AND DEATH: 6 mon
DUE TO
(b): and metastes
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1960

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 3

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 1, 19 67, to March 2, 19 67, that (I) (we) last saw the deceased alive on March 1, 19 67, and that death occurred at [X] M, from causes and on the date stated above.

22o. SIGNATURE: C. W. LeVan — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: March 3, 1967

22c. PHYSICIAN'S NAME (Type): C. W. LeVan 1

22d. ADDRESS: Boonsboro, Md

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-4-67

23c. NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery

23d. LOCATION (City or Town) (County) (State): Boonsboro, Md.

24. FUNERAL DIRECTOR ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md BP

25o. REC'D BY REGISTRAR DATE: MAR 7 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04357

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 1 Week
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21,1
   d. STREET ADDRESS: 2417 Penna Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

79

3. **NAME OF DECEASED** (Type or print): First GOLDIE — Middle DOROTHY — Lost DAY-WHITE

4. **DATE OF DEATH**: Month March — Doy 22 — Yeor 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 14 1888

9. AGE (In yeors last birthdoy) 78 yrs.

IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Mo — Prairie Hill Randolph Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Tyson Dameron

14. MOTHER'S MAIDEN NAME: Mollie Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes give war or dates of service) ----

16. SOCIAL SECURITY NO.: 523-30-0086A

17. **INFORMANT** — Address: Eldon J. Day 2417 Penna Ave

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Intercerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b): athrosclerosis, cerebral — years
DUE TO
(c):

331X

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

Hagerstown Md.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Diabetes mellitus; incidental fracture, left hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Pt. fell at home while getting into bed on 3/14/67

20c. TIME OF INJURY Month, Doy, Yeor: Hour 10:00 p.m. 3/14 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (Stote): Hagerstown Wash. Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 3/22/67

EXAMINER'S NAME (Type): Howard N. Weeks, M.D.

Address (Street, city, town, or county): 580 Northern Ave. Hagerstown, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 3/23/67

23c. NAME OF CEMETERY OR CREMATORY: Mt Carmel Cemetery

23d. LOCATION (City or Town) (County) (Stote): Huntsville Randolph Co Mo

24. FUNERAL DIRECTOR — ADDRESS: Andrew K. Coffman Funeral Home Inc Hagerstown Md

25o. REC'D BY REGISTRAR — DATE: MAR 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04357 — 04358

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 14 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro
d. STREET ADDRESS: 125 N. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dollie — Middle: May — Last: Wolfe

4. DATE OF DEATH: Month: March — Day: 30, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 8, 1876

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months: 5 — Days: 22
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Zittlestown, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Siman Summers

14. MOTHER'S MAIDEN NAME: Emma Zittle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 213-48-6193

17. INFORMANT Address: Mrs. William Lowery, Rfd. 4, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenteric thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
450.0
DUE TD
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last.
(b) arteriosclerotic disease — years
DUE TD
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January, 1966, to March, 1967, that (I) (we) last saw the deceased alive on March 30, 1967, and that death occurred at A M, from causes and on the dote stated above.

22a. SIGNATURE: H. N. Weeks M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/31/67

22c. PHYSICIAN'S NAME (Type): Howard N. WEeks, M.D.

22d. ADDRESS: 580 Northern Ave. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4- 1- 67

23c. NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery

23d. LOCATION (City or Town) (County) (State): Boonsboro, Md.

24. FUNERAL DIRECTOR ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.

25a. REC'D BY REGISTRAR DATE: APR 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge